

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06189

CERTIFICATE OF DEATH

06180

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYVILLE, MD		d. STREET ADDRESS GADD ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ARUNA H		First	Middle	Last	4. DATE OF DEATH 5 17 1967	Month	Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-5-44	9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months Days Hours Min. Address
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE W. Abell of A		14. MOTHER'S MAIDEN NAME CONSTANCE Gill					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-42-0919		17. INFORMANT FATHER - SAME ADDRESS			
18. CAUSE OF DEATH. (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA						INTERVAL BETWEEN ONSET AND DEATH WEEKS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)		DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-4 1967 , to 5-17 1967 , that (I) (we) lost saw the deceased alive on 5-16-1967 , and that death occurred at 12:00 AM , from causes and on the date stated above.							
22a. SIGNATURE R. Vieta		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Roland Vieta		22d. ADDRESS SPRING GROVE STATE HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF May-18-67		23c. NAME OF CEMETERY OR CREMATORIAL GreenMount		23d. LOCATION (City or Town) (County) (State) Baltimore Md. 21202	
24. FUNERAL DIRECTOR Stewart & Mowen Co 108-North-Av (21201)		ADDRESS		25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

08180

08180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE								
Baltimore MARYLAND				Maryland b. COUNTY								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
RURAL Baltimore				Baltimore								
c. LENGTH OF STAY IN 1b life				d. STREET ADDRESS 3409 White Ave								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)				First	Estelle	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Female				Caucasian	WIDOWED	DIVORCED	Adams	MAY	18	1967		
5. SEX				6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS			
						6/29/10	56 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?
Housewife								Baltimore Md.				USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME								
William Henry Price				Fanny Saunders								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address
Unknown				Unknown				Admission Sheet				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the lung with Metastasis DUE TO (c)												
INTERVAL BETWEEN ONSET AND DEATH 2 Months												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 5-9, 1967, to 5-18, 1967, that (I) (we) last saw the deceased alive on 5/17 1967, and that death occurred at 3:35 A.M., from the causes and on the date stated above.												
22a. SIGNATURE Derek A. Bruce				22b. DATE SIGNED 5/15/67								
22c. PHYSICIAN'S NAME (Type) DEREK A. BRUCE				22d. ADDRESS C.B.M.C.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/67		23c. NAME OF CEMETERY OR CREMATORIUM Moreland Memorial Park		23d. LOCATION (City, town or county) Baltimore		(State) Maryland				
24. FUNERAL DIRECTOR Robert C. Altenburg - 6009 Harford Rd. Funeral Home, Inc.		ADDRESS		25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge						

1213

62130
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH									
06191										06182									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. LENGTH OF STAY IN 1b 10mth6dys					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex, Maryland 21221									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					e. STREET ADDRESS 1644 Eastern Avenue					f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Charles M. Adams					4. DATE OF DEATH Month Day Year May 9 1967														
5. SEX male white					6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Sept. 30, 1884					9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 82 yrs. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) molding					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U. S.				
13. FATHER'S NAME Joseph Adams					14. MOTHER'S MAIDEN NAME Catherine Scriver														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK					16. SOCIAL SECURITY NO. 17. INFIRMANT 213-01-4135 Records: SPRING GROVE STATE HOSPITAL					Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					Arteriosclerotic cardiovascular disease														
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) Generalized arteriosclerosis, severe														
DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory					20f. (City or town) (County) (State) Baltimore, Maryland 21228				
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966, to May 9, 1967, that (we) last saw the deceased alive on May 9, 1967, and that death occurred at										22b. DATE SIGNED 5-9-67									
22a. SIGNATURE <i>Stella Wachsler</i>										M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228									
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 5/12/67					23c. NAME OF CEMETERY OR CREMATORIAL Maryland Mem.					23d. LOCATION (City, town or county) (State) Baltimore				
24. FUNERAL DIRECTOR <i>J. L. Connally Sons</i>					ADDRESS 300 More					25a. REC'D BY REGISTRAR DATE MAY 12 1967					25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

06192

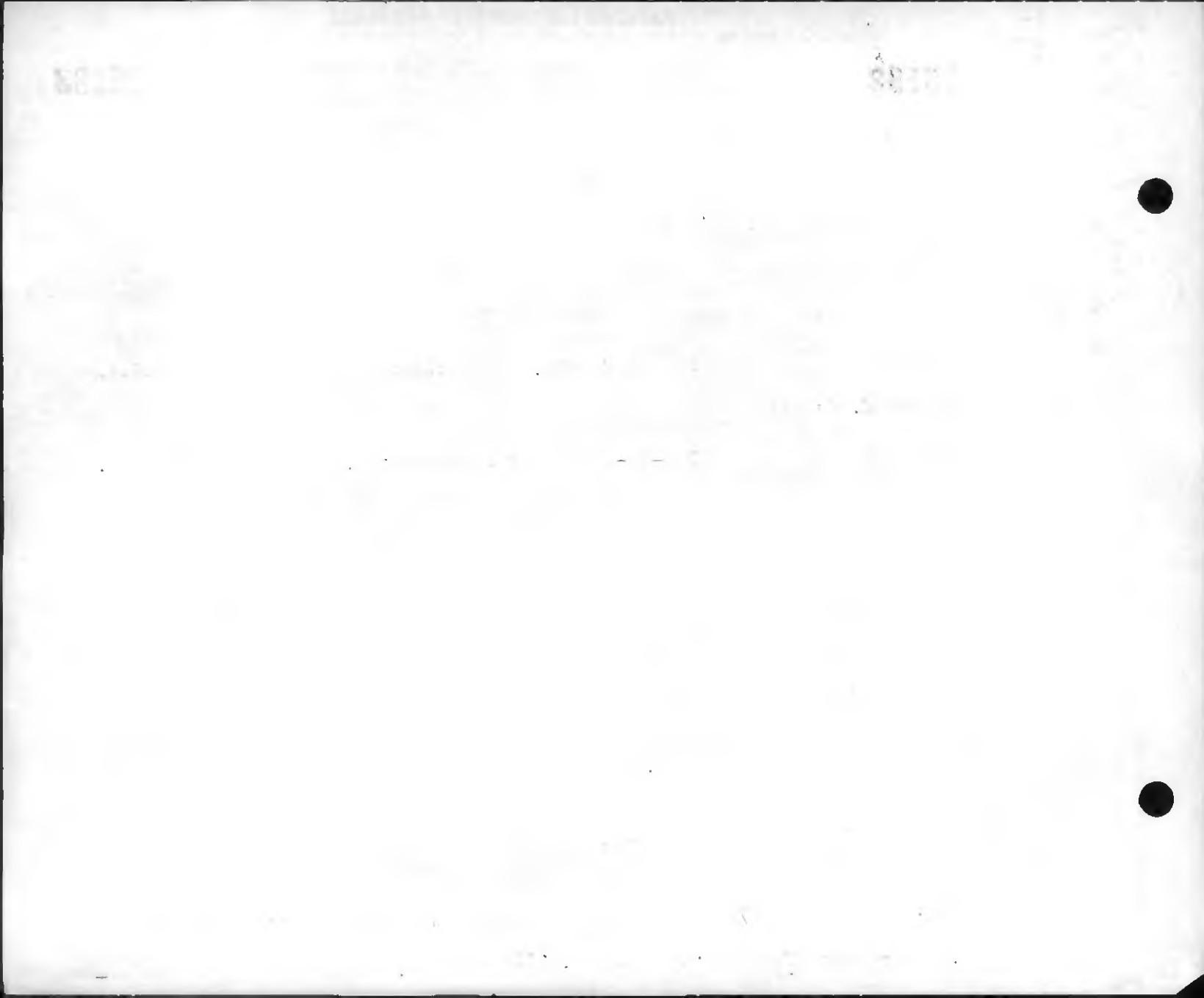
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06183

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE M.D.		b. COUNTY BALTO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN lb Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		d. STREET ADDRESS 238 BURKE AVE.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) VIRGINIA Denmead		First	Middle	Lost	4. DATE OF DEATH MAY 31 1967	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-85	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner		10b. KIND OF BUSINESS OR INDUSTRY Master TileCo.		11. BIRTHPLACE (State or foreign country) Baltimore, Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joshua T. Kelley				14. MOTHER'S MAIDEN NAME May Parks				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-30-5144		17. INFORMANT Mrs. Virginia D. Ruley 238 Burke Ave.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION						INTERVAL BETWEEN ONSET AND DEATH		
4301 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b)		DUE TO Due to (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>William A. Pillsbury</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-31-67		
EXAMINER'S NAME (Type) William A. Pillsbury		M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/67		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		ADDRESS		25a. REC'D BY REGISTRAR JUN 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



1
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06193

CERTIFICATE OF DEATH

06184

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<i>Baltimore</i>		a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Parkton - Rural</i>	<i>68 years</i>	<i>Parkton - Rural</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Mt Carmel Road</i>		<i>Mt Carmel Road</i>	

3. NAME OF DECEASED (Type or print)	First <i>Florence</i>	Middle <i>Virginia</i>	Last <i>Alban</i>	4. DATE OF DEATH	Month <i>May</i>	Day <i>18</i>	Year <i>1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	9. AGE (In years, last birthday) <i>94</i>	IF UNDERR 1 YEAR Months <i>76</i>	IF UNDERR 24 MRS. Days <i>yrs.</i>	Hours <i>Min.</i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Freeland Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
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13. FATHER'S NAME <i>John Mc Conn</i>	14. MOTHER'S MATURE NAME <i>Virginia AYRES</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>218-22-4992</i>	17. INFORMANT <i>Mrs Mary Ruth Wilhite Parkton Md</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1221</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Congestive heart failure</i>
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) OUE TO (c)	<i>Congestive heart failure</i>	

2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Hampstead</i>	(County) <i>Hampstead</i>	(State) <i>Maryland</i>

21. I certify that (I) (this hospital) attended the deceased from *4-18*, 1967, to *5-18*, 1967, that (I) (we) last saw the deceased alive on *4-18*, 1967, and that death occurred at *20* M, from the causes and on the date stated above.

22a. SIGNATURE *Joseph E. Bush*

22c. PHYSICIAN'S NAME (Type) *Joseph E. Bush MD*

23a. BURIAL, CREMATION, REMOVAL (Specify) *BURIAL*

23b. DATE THEREOF *5/21/67*

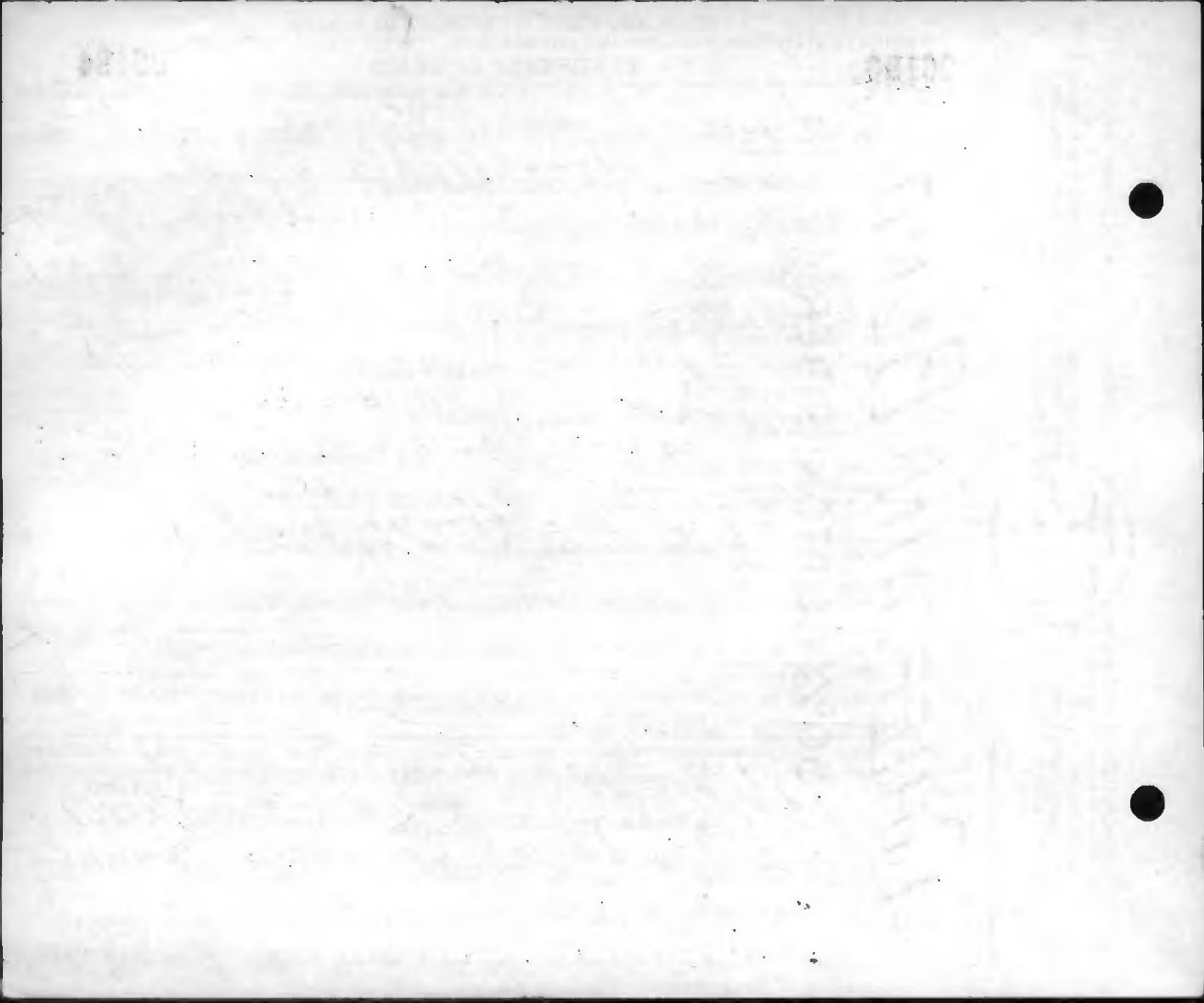
23c. NAME OF CEMETERY OR CREMATORIAL *PINEGROVE*

23d. LOCATION (City, town or county) (State) *PARKTON, MD.*

24. FUNERAL DIRECTOR *John E. Goff - HAMPTON, MD.*

25a. REC'D BY REGISTRAR *Charles Judge*

25b. REGISTRAR'S SIGNATURE *Charles Judge*



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06194

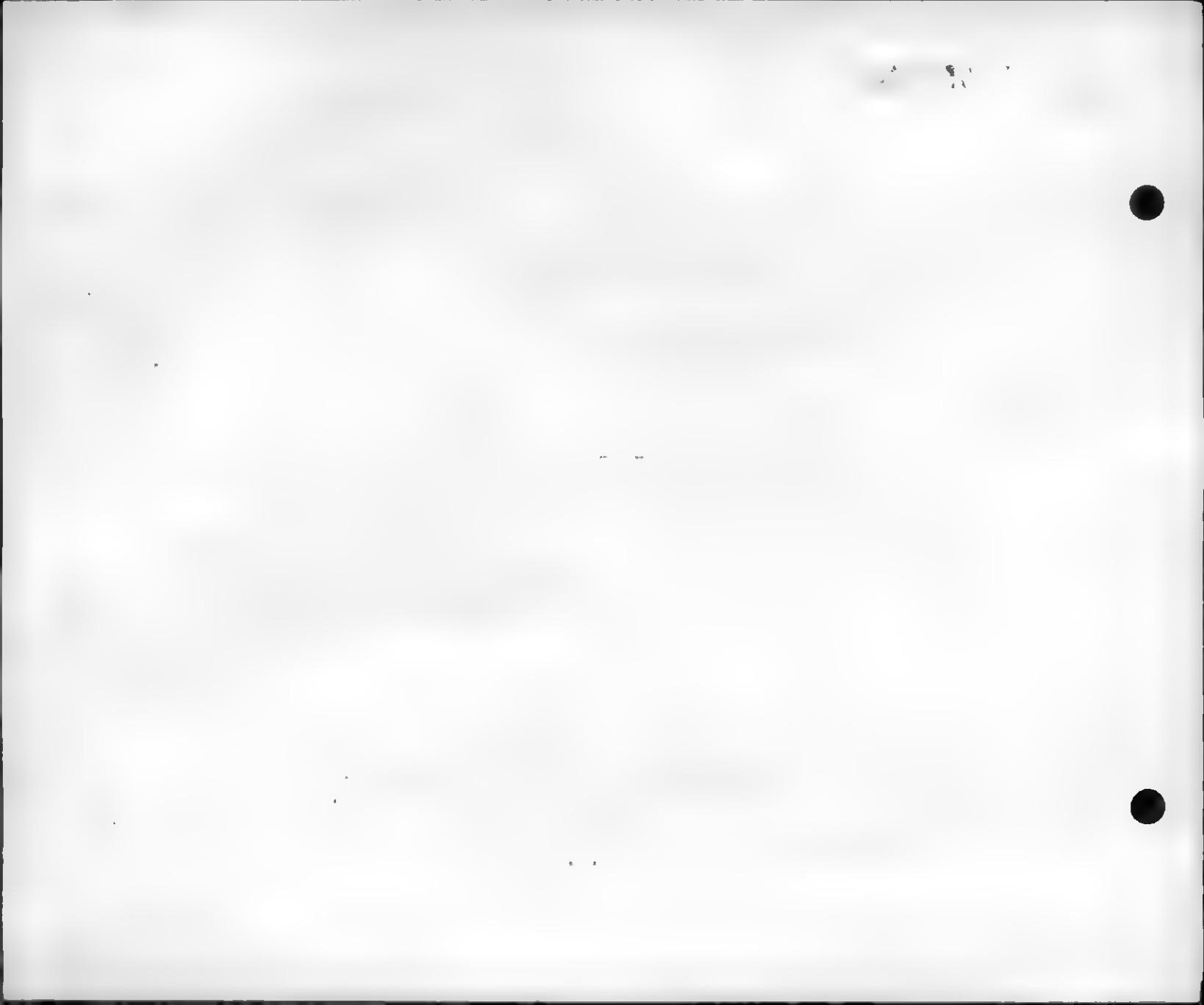
CERTIFICATE OF DEATH

37681

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 23yr2mth6dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2101 Cold Spring Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle (Kratz) Last Alexander		4. DATE OF DEATH Month May Day 22 Year 1967	
S SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 3, 1896
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) guard		9 AGE (In years at last birthday) 70 yrs	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME John Kratz		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-6680 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pyelonephritis with uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c) <i>Generalized arteriosclerosis, severe</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 13, 1967, to May 22, 1967, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on May 22, 1967, and that death occurred at 2:45 P.M. from causes and on the date stated above			
22a. SIGNATURE <i>Stella Wachsler</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 5-22-67
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 22, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Casimir Cemetery</i>
24. FUNERAL DIRECTOR <i>John K. Kratz</i>		ADDRESS <i>1101 Cold Spring Lane</i>	25a. REC'D. BY REGISTRAR JUN 7 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

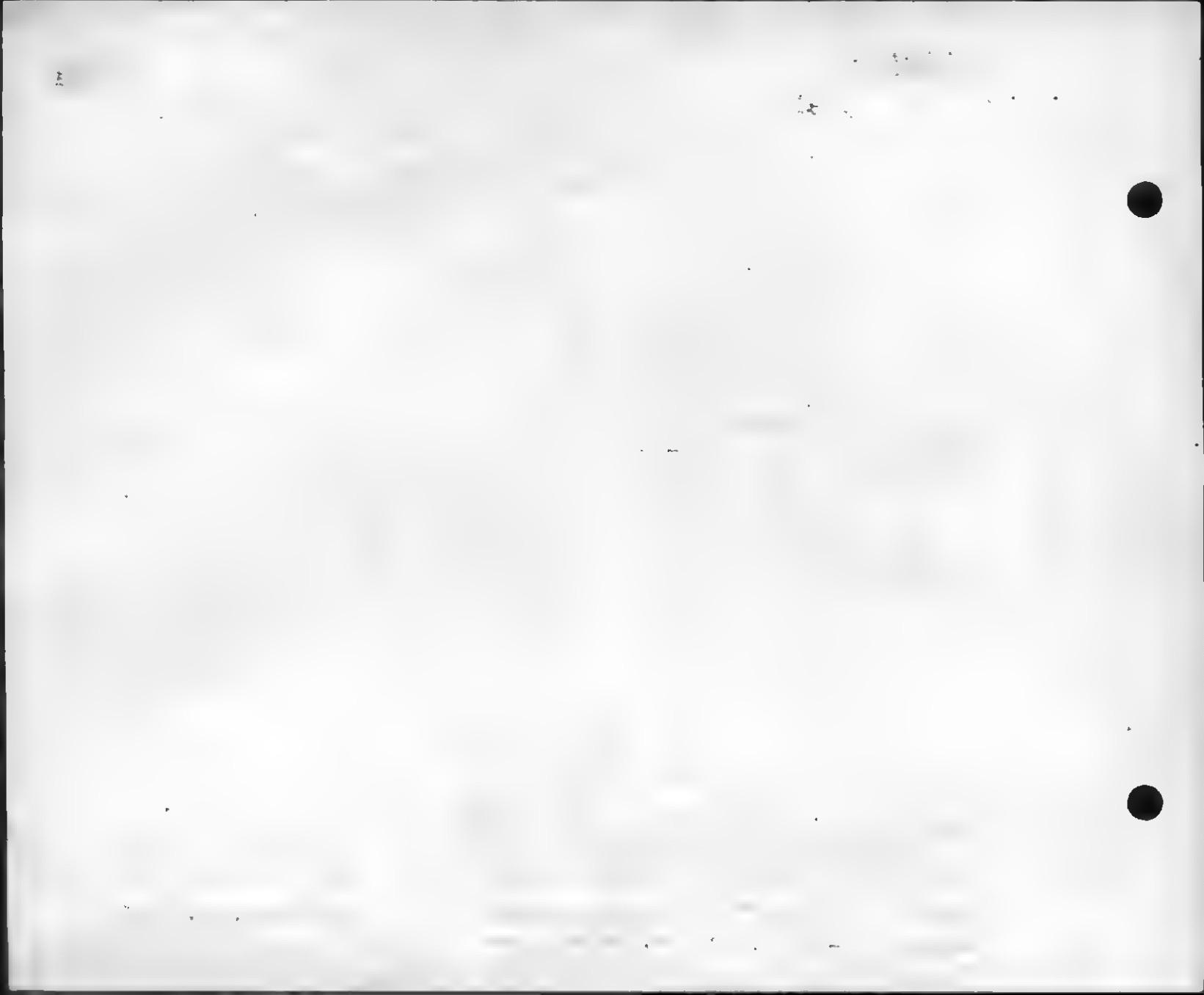
CERTIFICATE OF DEATH

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The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. *Pg 3 1/2*
1/2 hours after death

CERTIFICATE OF DEATH						06186		
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b 135 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 1420 SOUTH CHARLES STREET			e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First JACK	Middle PHILLIP	Lost AMBROSE	4. DATE OF DEATH MAY 20, 1967	Month MAY	Doy 20	Year 1967	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/19	9. AGE (In years last birthday) 47 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10. US J.A.L. OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN			10b. KIND OF BUSINESS OR INDUSTRY RAILROAD			11. BIRTHPLACE (County & State, or foreign country) FREDERICK, MARYLAND		
13. FATHER'S NAME DAVID L. AMBROSE			14. MOTHER'S MAIDEN NAME MARY PHILLIPS			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII			16. SOCIAL SECURITY NO 214 14 17 78			17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			DUE TO DUE TO (c)			INTERVAL BETWEEN DEATHS (months) MONTHS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour: o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VAH (this hospital) attended the deceased from JAN 5, 1967 to MAY 20, 1967 , that we last saw the deceased alive on MAY 20, 1967 , and that death occurred at 8:10PM , from causes and on the date stated above.								
22a. SIGNATURE <i>Peter V. Juvan</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 5/20/67		
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M.D.			22d. ADDRESS VAH, FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67		23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR CHAS. L. STEVENS FUNERAL HOME		ADDRESS 1501 E. FORT AVE. BALTO., MD.		25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 25M 1/67								

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06197

CERTIFICATE OF DEATH

06197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write R.R.# and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write R.R.# and give nearest town) Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. fa., give street address) Spring Grove State Hospital		d. STREET ADDRESS 1711 Wilkens Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bertha A. Appler	First	Middle	Last
4. DATE OF DEATH MAY 6 1967	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 8-19-93		9. AGE (In years last birthday) 73 yrs	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph		14. MOTHER'S MAIDEN NAME Marie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 49.2 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) (County) (State) None			
21. I certify that (Ic)(this hospital) attended the deceased from April 20, 1967 , to 5/6 1967 , that (Ic)(we) last saw the deceased alive on 5/6 1967 , and that death occurred at 2:25 AM , from causes and on the date stated above.			
22a. SIGNATURE Frederick W. Barnes, M.D.		22b. DATE SIGNED 5/6/67	
22c. PHYSICIAN'S NAME (Type) NARCISO R. BARNES		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Honden Park		23d. LOCATION (City or Town) (County) (State) Baltimore, MD	
24. FUNERAL DIRECTOR Walter Fitt. Baets M.d.		25a. REC'D. BY REGISTRAR MAY 8 1967	
		25b. REGISTRAR'S SIGNATURE Jessica Jorg	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

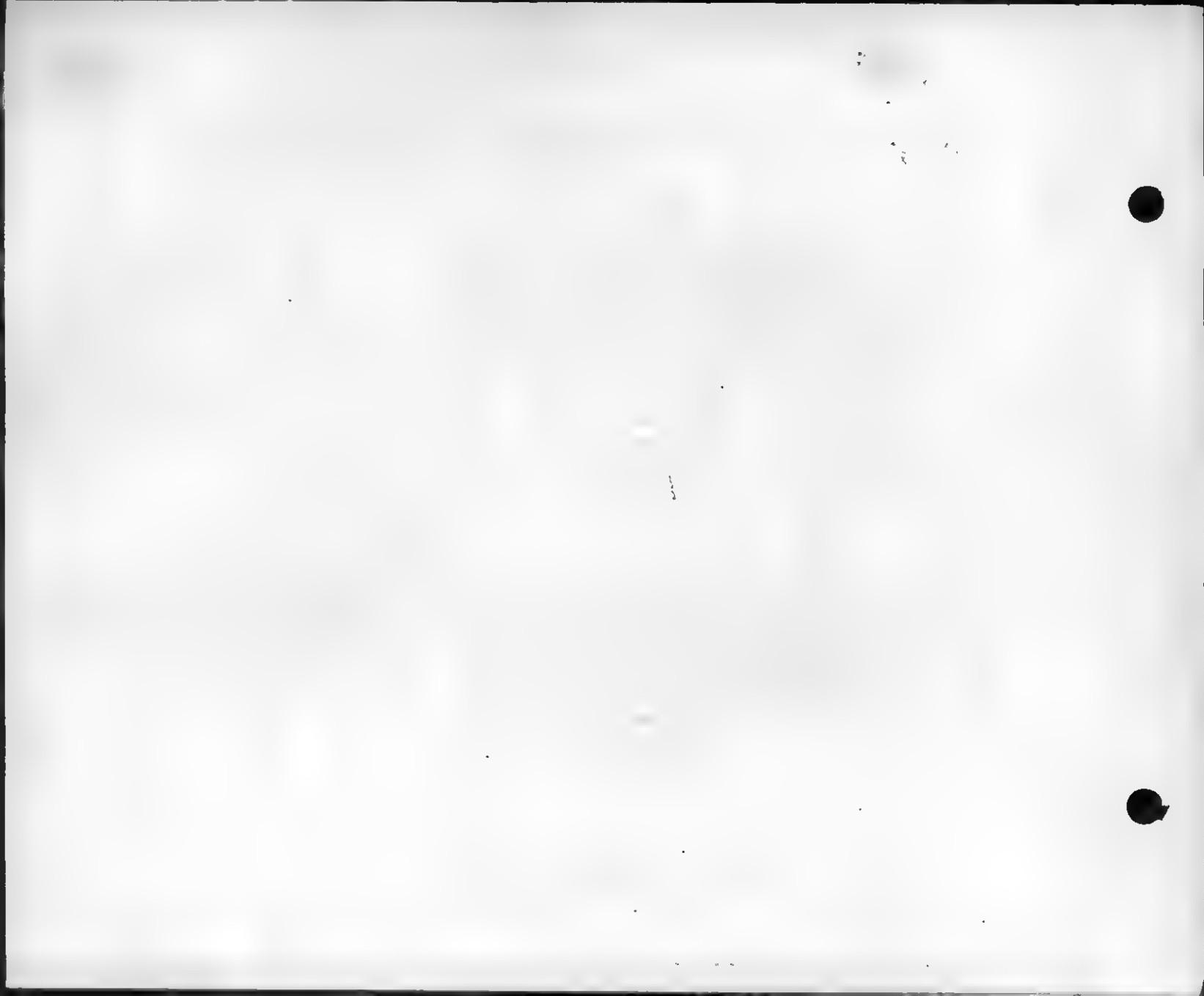
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06198

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>BALTIMORE</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Woodlawn</i>		c. LENGTH OF STAY IN 1b <i>7 Years</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>2121 GWYNN OAK AVE</i>		e. STREET ADDRESS <i>5800 WINDSOR MILLS</i>		
3. NAME OF DECEASED (Type or print) <i>WILLIAM ERNEST ARMACOST</i>		First <i>W</i>	Middle <i>E</i>	
4. DATE OF DEATH <i>5 2 1967</i>	Month <i>5</i>	Day <i>2</i>	Year <i>1967</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <i>12/15/1910</i>	
9. AGE (in years last birthday) <i>56 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BARBER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>BARBER</i>	11. BIRTHPLACE (County & State, or foreign country) <i>No</i>		
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>JOHN E. ARMACOST</i>			
14. MOTHER'S MAIDEN NAME <i>NINA R. McCOLLOUGH</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>212-05-4839</i>	17. INFORMANT <i>MARGARET ARMACOST - 2121 GWYNN OAK AVE</i>	Address <i>BALTO. 21207 MD</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>154X</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>CARCINOMA & METASTASES (OF RECTUM)</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 YEARS.</i>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work Not While at work <i>Not While at work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At home</i>	20f. (City or town) (County) (State) <i>BALTO. 21207 MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>OCT 15, 1953</i> to <i>MAY 2, 1967</i> , that (I) (we) last saw the deceased alive on <i>APRIL 30, 1967</i> , and that death occurred at <i>415A</i> , from the causes and on the date stated above.				
22a. SIGNATURE <i>Edwin E. Pierpoint</i>		22b. DATE SIGNED <i>5/2/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>EDWIN E. PIERPOINT, M.D.</i>	M.D. <input checked="" type="checkbox"/>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5-5-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Woodlawn Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Md</i>	
24. FUNERAL DIRECTOR <i>Ellsworth Armacost - 4600 Liberty Heights Ave</i>	25a. REC'D BY REGISTRAR <i>MAY 1967</i>	25b. REGISTRAR'S SIGNATURE		



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event, within 72 hours of the death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

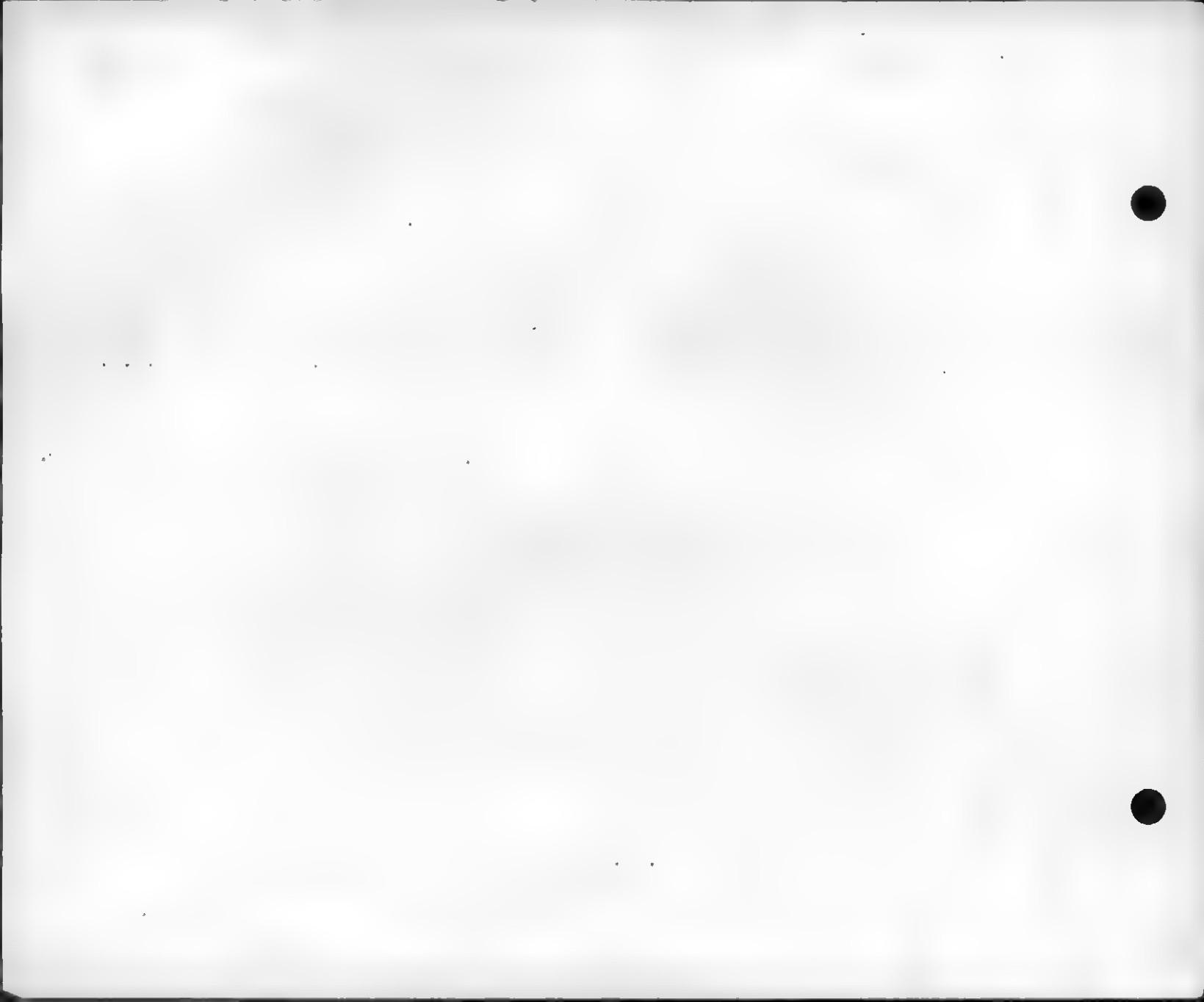
Item 23b, MARYLAND G309 5-24-67 kk

06199

CERTIFICATE OF DEATH

06189

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	c. LENGTH OF STAY IN Tb 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21201	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 770 W. SARATOGA STREET, APT 203	
3 NAME OF DECEASED (Type or print)	First MARVIS	Middle A.	4 DATE OF DEATH Month MAY Day 16 Year 1967
5 SEX FEMALE	6 COLOR OR RACE NEGRO	7 MARRIED WIDOWED Separated	8 DATE OF BIRTH APRIL 13, 1932
9 AGE (In years less birthday) 35 yrs		9 IF UNDER 1 YEAR Months 0 Days 0	10 IF UNDER 24 HRS Hours 0 Min 0
10b KIND OF BUSINESS OR IND. STRY HOSPITAL		11 BIRTHPLACE (County & State, or foreign country) GREENVILLE, N. C.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13 FATHER'S NAME JESSIE ALLEN		14 MOTHER'S MAIDEN NAME ROSETTA DICKSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 219 34 67 77	17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOLYTIC CRISIS		INTERVAL BETWEEN ONSET AND DEATH RECENT	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SICKLE CELL ANEMIA		UNKNOWN	
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH FORT HOWARD, MARYLAND
20f. (City or town) BALTIMORE, MD.		(County) (State)	
21. I certify that VAH (this hospital) attended the deceased from 5/14/67 , 19 67 , to 5/16/67 , 19 67 , that (X) (we) last saw the deceased alive on 5/16/67 , 19 67 , and that death occurred at 12:10 PM causes and on the date stated above.			
22a. SIGNATURE George Dudas,		MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 5/16/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/20/67	23c. NAME OF CEMETERY OR CREMATORIAL ARUBUS MEMORIAL CEMETERY
24. FUNERAL DIRECTOR 1727 N. Monroe St.		ADDRESS PHILLIPS FUNERAL HOME	25a. REC'D BY REGISTRAR DATE MAI 22 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

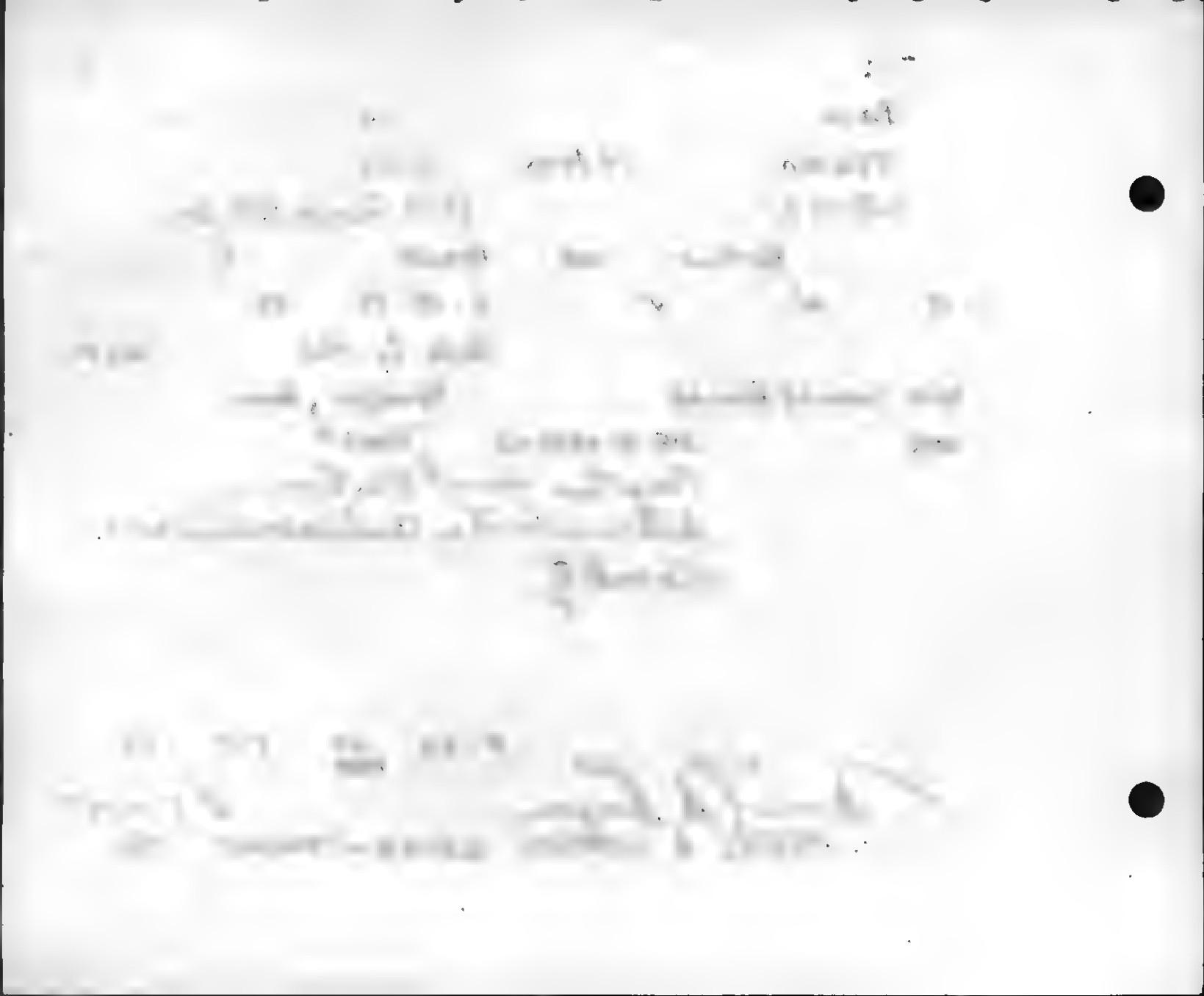


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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE											
a. COUNTY Baltimore		b. COUNTY Baltimore											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 14 days											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GB.M.C.		d. STREET ADDRESS 5509 Gwynn Oak Ave											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First Arthur	Middle NM	Last Arnold	4. DATE OF DEATH 5 11 1967	Month 5	Day 11	Year 1967					
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-75	9. AGE (in years last birthday) 92 yrs.	10. IF UNDER 1 YEAR Months 92	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder			10b. KIND OF BUSINESS OR INDUSTRY Construction			11. BIRTHPLACE (County & State, or foreign country) Baltimore Co. Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Wm. Samuel Arnold			14. MOTHER'S MAIDEN NAME Younger, Anna			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK			16. SOCIAL SECURITY NO. 218-18-0833-51			17. INFORMANT Raymond A. Arnold	Address 600 Coventry Rd
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)			INTERVAL BETWEEN ONSET AND DEATH										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Congestive Heart Failure										
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			Arteriosclerotic Cardiovascular Disease										
(b)			Senility										
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
19													
21. I certify that (I) (this hospital) attended the deceased from 4-26 1967 , to 5-11 1967 , that (I) (we) last saw the deceased alive on 5-10 1967 , and that death occurred at 12:00 AM , from the causes and on the date stated above.													
22a. SIGNATURE Manuel A. Gongon									22b. DATE SIGNED 5-11-67				
22c. PHYSICIAN'S NAME (Type) MANUEL A. GONGON			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22d. ADDRESS GBMC - Towson, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 13, 1967			23c. NAME OF CEMETERY OR CREMATORIAL Hereford Bap. Ch. Cent Hereford, Md.			23d. LOCATION (City, town or county) (State) Edmondson Ave.				
24. FUNERAL DIRECTOR STERLING FUNERAL ESTATE			ADDRESS Catonsville, Md.			25a. REC'D BY REGISTRAR MAY 15 1967			25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)								
a. COUNTY <i>Baltimore</i>				b. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>				c. LENGTH OF STAY IN 1b <i>2 yrs.</i>								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4714 Washington Blvd.</i>				d. STREET ADDRESS <i>4714 Washington Blvd</i>								
3. NAME OF DECEASED (Type or print) <i>Renee Arthur</i>				First <i>Renee</i>	Middle <i>Arthur</i>	Last <i></i>	4. DATE OF DEATH <i>May 1, 1967</i>	Month <i>19</i>	Day <i></i>	Year <i></i>		
5. SEX <i>Female</i>				6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>10/8/82</i>	9. AGE (in years last birthday) <i>84 yrs.</i>	IF UNDER 1 YEAR <i></i>	IF UNDER 24 HRS. <i></i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Penn.</i>				12. CITIZEN OF WHAT COUNTRY? <i></i>
13. FATHER'S NAME <i>George R. Hayden</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Hixson</i>				Address <i>Mary H. Goff 4714 Washington Blvd</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>219-54-4146</i>				17. INFORMANT <i>Carrie Brumbaugh</i>				INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular disease</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis</i>				DUE TO (b) <i>clotting</i> DUE TO (c) <i>constrictions of age</i>								<i>10 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Has been blind for 5 yrs</i>												
20a. ACCIDENT WAS UNDERLYING DR. CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i></i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>				20f. (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from <i>Jan 1967</i> to <i>May 1967</i> , that (I) (we) last saw the deceased alive on <i>April 29 1967</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.												
22a. SIGNATURE <i>Dr. Renee B. Brumbaugh</i>												
22b. DATE SIGNED <i>May 1967</i>												
22c. PHYSICIAN'S NAME (Type) <i>Dr. Renee B. Brumbaugh</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>5/2/67</i>				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Meadow Ridge Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore Maryland</i>
24. FUNERAL DIRECTOR <i>Ambrose J. 1329 Sulphur Sq. Rd</i>				25a. REC'D BY REGISTRAR <i>MAY 4 1967</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06202

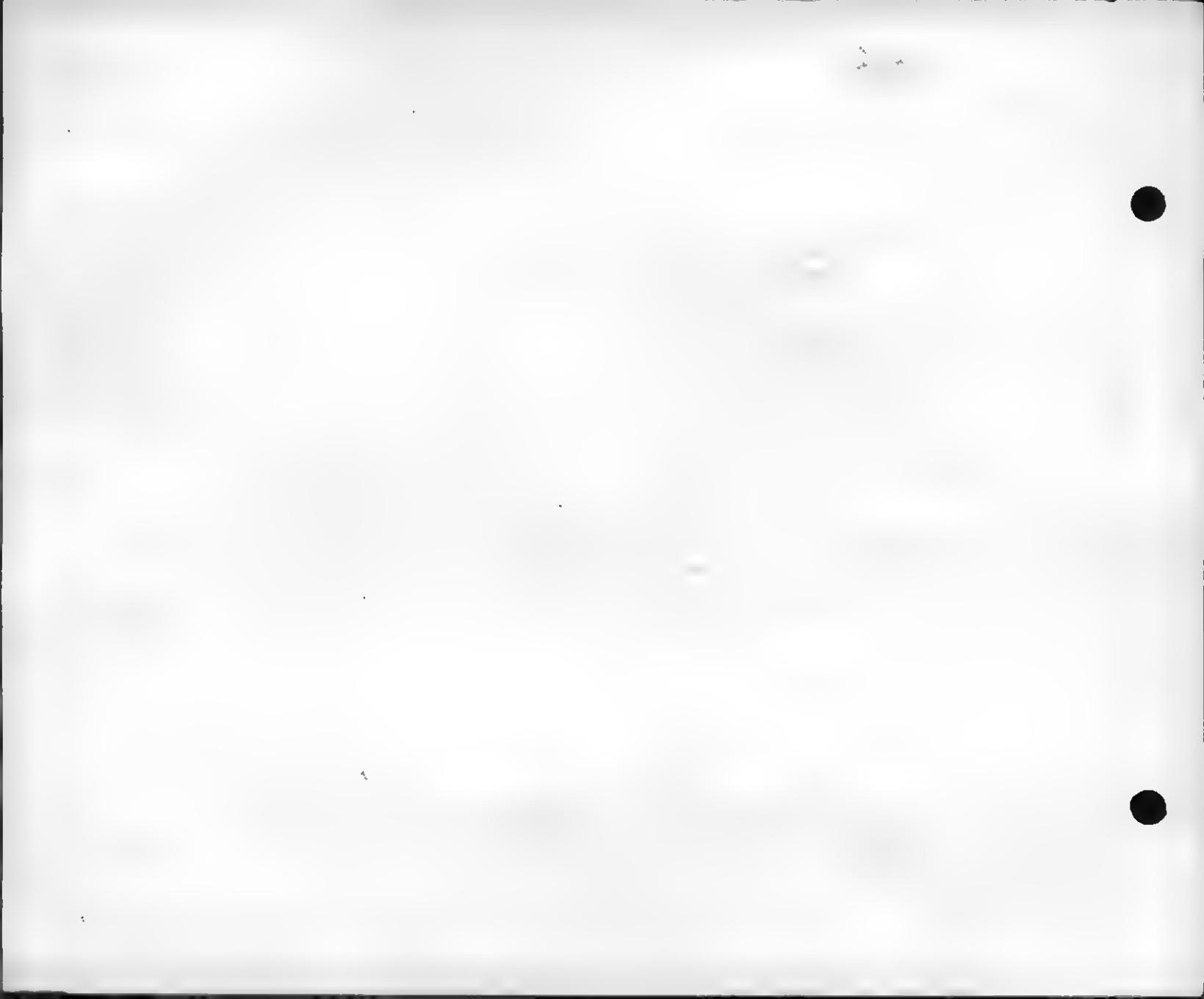
CERTIFICATE OF DEATH

06192

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the funeral.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c LENGTH OF STAY IN lb 6 YEARS	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE, MD
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ARMACOSTI NURSING HOME		d. STREET ADDRESS 1014 N. CHARLES ST	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MAE	Middle N.	Last BACHMANN
4. DATE OF DEATH Month MAY Day 16 Year 1967	Month Month Day Day Year Year	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
5. SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH MAY 22 1877
9 AGE (In years at birthday) 89 yrs	10b KIND OF BUSINESS OR INDUSTRY CRIME DETECTION	11 BIRTHPLACE (County & State or foreign country) CARLISLE, PENNSYLVANIA	12 CITIZEN OF WHAT COUNTRY U.S.A.
13 FATHER'S NAME PHILIP NORMAN	14. MOTHER'S MAIDEN NAME MATTIE (NOT KNOWN)		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No	16 SOCIAL SECURITY NO	17 INFORMANT C. RAY FREHN, 118 PARKER STREET, CARLISLE, PA.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 4 Months 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 614 1/2	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/14/67 to May 16, 1967 , that (I) (we) last saw the deceased alive on 5/2/67 , and that death occurred at 614 1/2 , from causes and on the date stated above.			
22a SIGNATURE Charles F. O'Donnell	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED 22 May 1967	
22c PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D.	22d ADDRESS		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF MAY 18, 1967	23c NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery	23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR Wm Cook Brooks TOWSON	ADDRESS 1050 York ROAD TOWSON, MD 21204	25a REC'D BY REG. STRAR MAY 22 1967	25b REGISTRAR'S SIGNATURE Charles J. Judge



1
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FOR STATE
HEALTH DEPT.

TO DEPUTY VITAL EXAMINER: This certificate should be executed within 24 hours after death if 3 day delay is necessary please execute the certifcate writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

06203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #13 & 14 Film #G3859161 p3

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06193

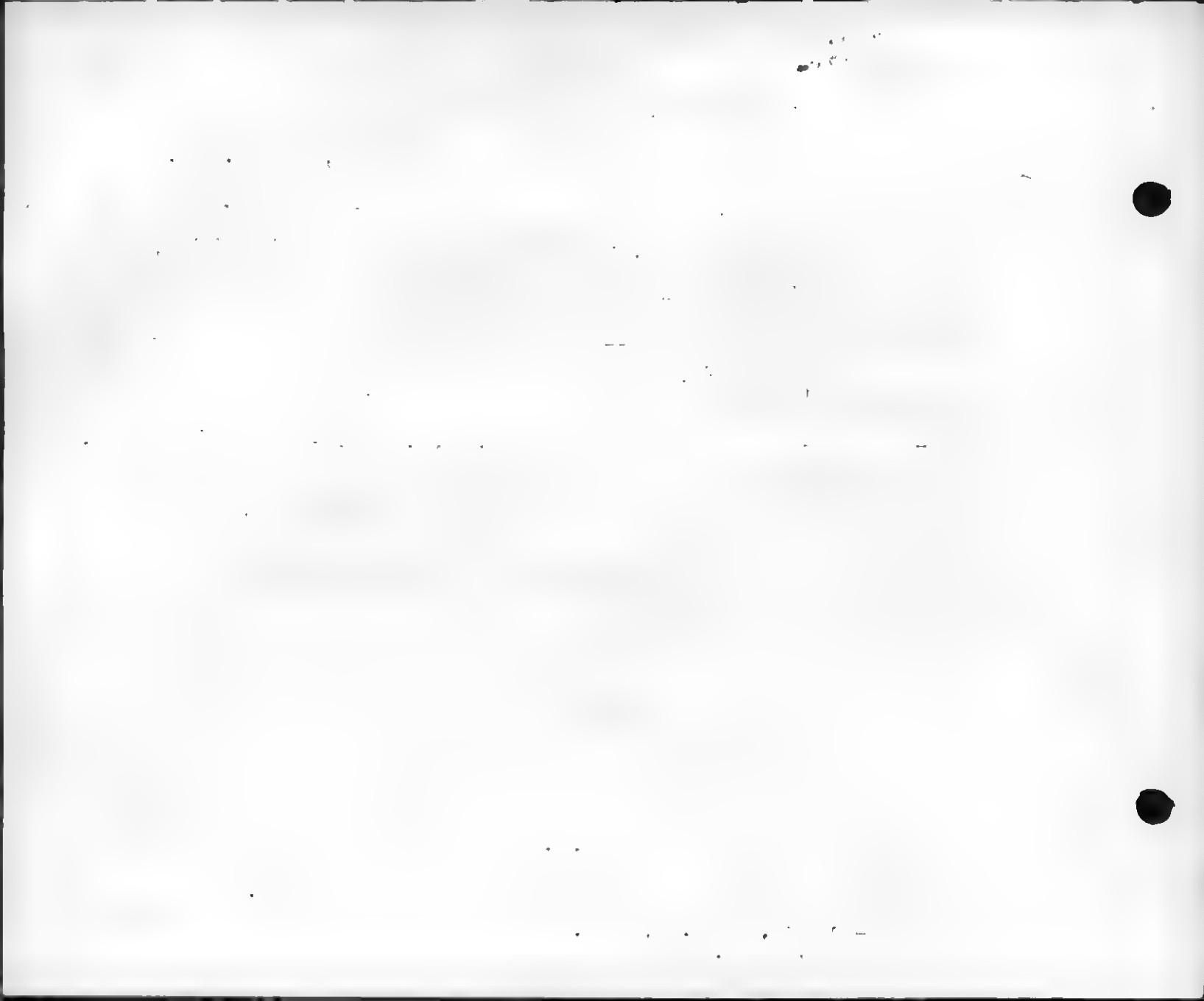
1 PLACE OF DEATH a COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived) <input type="checkbox"/> institution Residence before admission a STATE Maryland b COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Dundalk		c LENGTH OF STAY N 16		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 7302 School Lane			d STREET ADDRESS 7302 School Lane			e 5 RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
3 NAME OF DECEASED (Type or print) Orval		First Roy	Middle Baker	Last Baker	4 DATE OF DEATH May 3 1967	Month Doy Year
S SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B DATE OF BIRTH April 16, 1899	9 AGE (in years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b KIND OF BUSINESS OR INDUSTRY Steel		11 BIRTHPLACE (State or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Samuel Baker			14 MOTHER'S MAIDEN NAME Kimball Baker			Address
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 236-01-8725		17 INFORMANT Mrs. Edna N. Baker		18
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) DUE TO (c)		Coronary Occlusion Hypertension C-V-Disease		INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE M.B. Davis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED MAY 5 1967		
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a PURCHASE/CREMATION REMOVAL (Specify) Burial		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
23b DATE THEREOF 5/6/67		ADDRESS Baltimore Cemetery		Address (Street, city, town or county) 6800 Mornington Rd., Baltimore, Md.		
24 FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.		23d DEATH (City or Town) Baltimore, Md.		23d DEATH (State) Md.		
25a REC'D BY REG'LAR MAY 5 1967		25b REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
16204			5104										
1. PLACE OF DEATH a. COUNTY.		Baltimore 9807 Hilltop Brive MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					b. STATE Maryland		b. COUNTY						
c. LENGTH OF STAY IN 1D					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville, Balto. Co.								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9807 Hilltop Drive					d. STREET ADDRESS 9807 Hilltop Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First MARGARET E.		Middle BARLOW	Last		4. DATE OF DEATH May 17th,	Month	Day	Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1880		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas O'Neill				14. MOTHER'S MAIDEN NAME Julia Keelty									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. J.E. Albert-9807 Hilltop Dr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Generalized Arteriosclerosis with Cerebral Thrombosis → 8 hrs.											
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		Chronic Cardiac Decompensation		10 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Balto.		(County)	(State)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
21. I certify that (I) (This hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.													
22a. SIGNATURE Thomas J. Brennan		22b. DATE SIGNED 19 May 1967		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Thomas Brennan M.D.		22d. ADDRESS 5217 Harford Road											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/20/67		23c. NAME OF CEMETERY OR CREMATORIAL Cathedral Cem		23d. LOCATION (City, town or county) Balto.		(State)					
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. 21212		ADDRESS		25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							
DATE MAY 23 1967													



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36205
Baltimore County

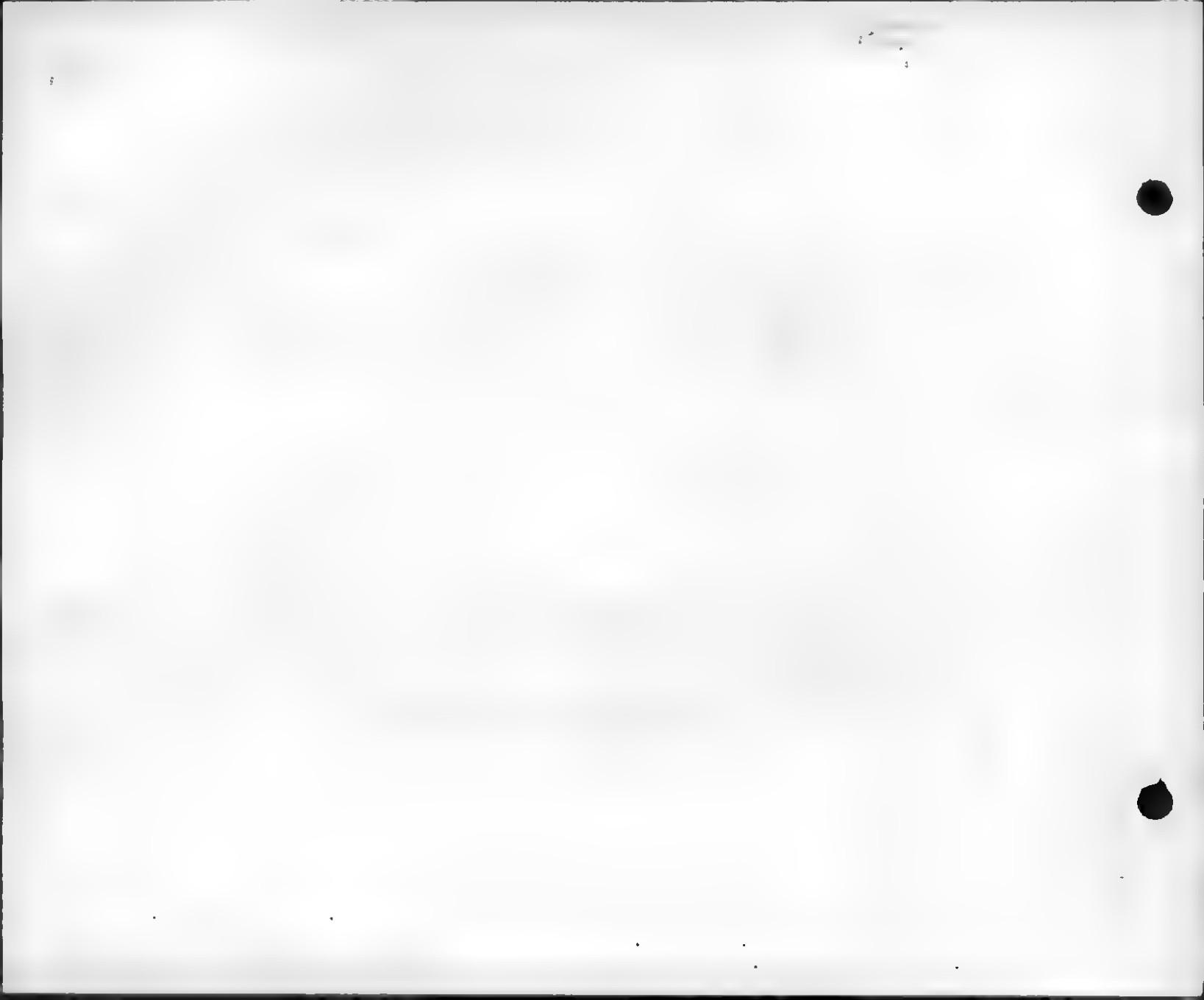
CERTIFICATE OF DEATH

OC195

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb <i>116 in Baltimore</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>over 70 years + Miss Mary</i>		e. STREET ADDRESS <i>Baltimore Maryland</i>		
3. NAME OF 'DECEASED' (Type or print) <i>Mary L. Bartlett</i>		First <i>Mary</i>	Middle <i>Lia</i>	
Last <i>Bartlett</i>		4. DATE OF DEATH <i>May 11 1967</i>	Month Day Year <i>May 11 1967</i>	
S SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <i>8-10-1877</i>	8. AGE (In years last birthday) <i>89 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House keeper</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore Md.</i>	9. IF UNDER 1 YEAR Months <i>9</i>	
13. FATHER'S NAME <i>A. J. S. Fisher Bartlett</i>	14. MOTHER'S MADDEN NAME <i>Judie M. Fisher</i>	12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	10. IF UNDER 24 HRS Days <i>11</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Judge M. J. T. 613 Bartlett</i>	Address <i>Address</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intestinal disease</i> DUE TO <i>old age</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intestinal disease</i> DUE TO <i>old age</i> ONSET AND DEATH (c) <i>Intestinal disease</i> DUE TO <i>old age</i> <i>years</i>				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Biliary cirrhosis, liver problem</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>May 11 1967</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , to <i>May 11, 1967</i> , that (I) (we) last saw the deceased alive on <i>July 9, 1967</i> , and that death occurred at <i>11:30 AM</i> , from causes and on the date stated above.				
22a. SIGNATURE <i>Neeland Edward Day</i>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>May 16 1967</i>
22c. PHYSICIAN'S NAME (Type) <i>Neeland Edward Day</i>	22d. ADDRESS <i>4-8-33rd St Baltimore MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/13/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Greenmount</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>1217 St. Paul St.</i>	ADDRESS <i>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</i>	25a. REC'D BY REGISTRAR DATE <i>MAY 16 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06206

16196

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1B 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armacost N. H.		d. STREET ADDRESS 105 Chestnut St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle William	Last Beall
4. DATE OF DEATH Month May	Day 1	Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1887
9. AGE (in years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 4439 Old York Rd.	11. IF UNDER 24 HRS. Days Balto., Md.	12. COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Mail Clerk	10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Charles E. Beall	14. MOTHER'S MAIDEN NAME Mary E. Clements		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 577-58-8836	17. INFORMANT Mrs. Mary E. O'Brien	Address 4439 Old York Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lymphatic Sarcoma</i>	DUE TO (b)	DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (a)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4439 Old York Rd.	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 10, 1967 to May 1, 1967 , that (I) (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 4439 Old York Rd. from the causes and on the date stated above.			
22a. SIGNATURE <i>Laurence C. Post</i>	22b. DATE SIGNED 5/1/67		
22c. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post	M.D. <input type="checkbox"/> ATTENDING PHYS. 5/1/67	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS 6805 York Rd., Balto., 12, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-3-67	23c. NAME OF CEMETERY OR CREMATORIAL St. Rose	23d. LOCATION (City, town or county) (State) Gaithersburg Md.
24. FUNERAL DIRECTOR H.W.Jenkins & Sons Co.	ADDRESS 4905 York Rd. Balto., Md.	25e. REC'D BY REGISTRAR MAY 2 1967	25f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06207

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH c. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) c. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN b. 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gatonsville	b. COUNTY Baltimore							
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) 608 Stacy Court			d. STREET ADDRESS 3229 3229 Shelburne Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Anna	Middle Mary	Last Beeler	4. DATE OF DEATH Month May	Month 2	Day 1967				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1893	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not employed			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin Holland			14. MOTHER'S MAIDEN NAME Delia Grady							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service NO			16. SOCIAL SECURITY NO 217-03-4821			17. INFORMANT Mr. Charles Beeler 608 Stacy Court			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 11/01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { (b) art sel cv disease } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 15 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year Hour a.m. None 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/4, 1965 to 5/2, 1967 , that (I) (we) last saw the deceased alive on 5/2, 1968 , and that death occurred at 11 P.M. , from causes and on the date stated above										
22a. SIGNATURE Maurice Feldman Jr.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/3/67			
22c. PHYSICIAN'S NAME (Type) Burial			22d. ADDRESS 26 READ ST							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 5, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland				
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson			ADDRESS 1050 York Road Towson, Maryland 21204			25a. REC'D BY REGISTRAR MAY 5, 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36208

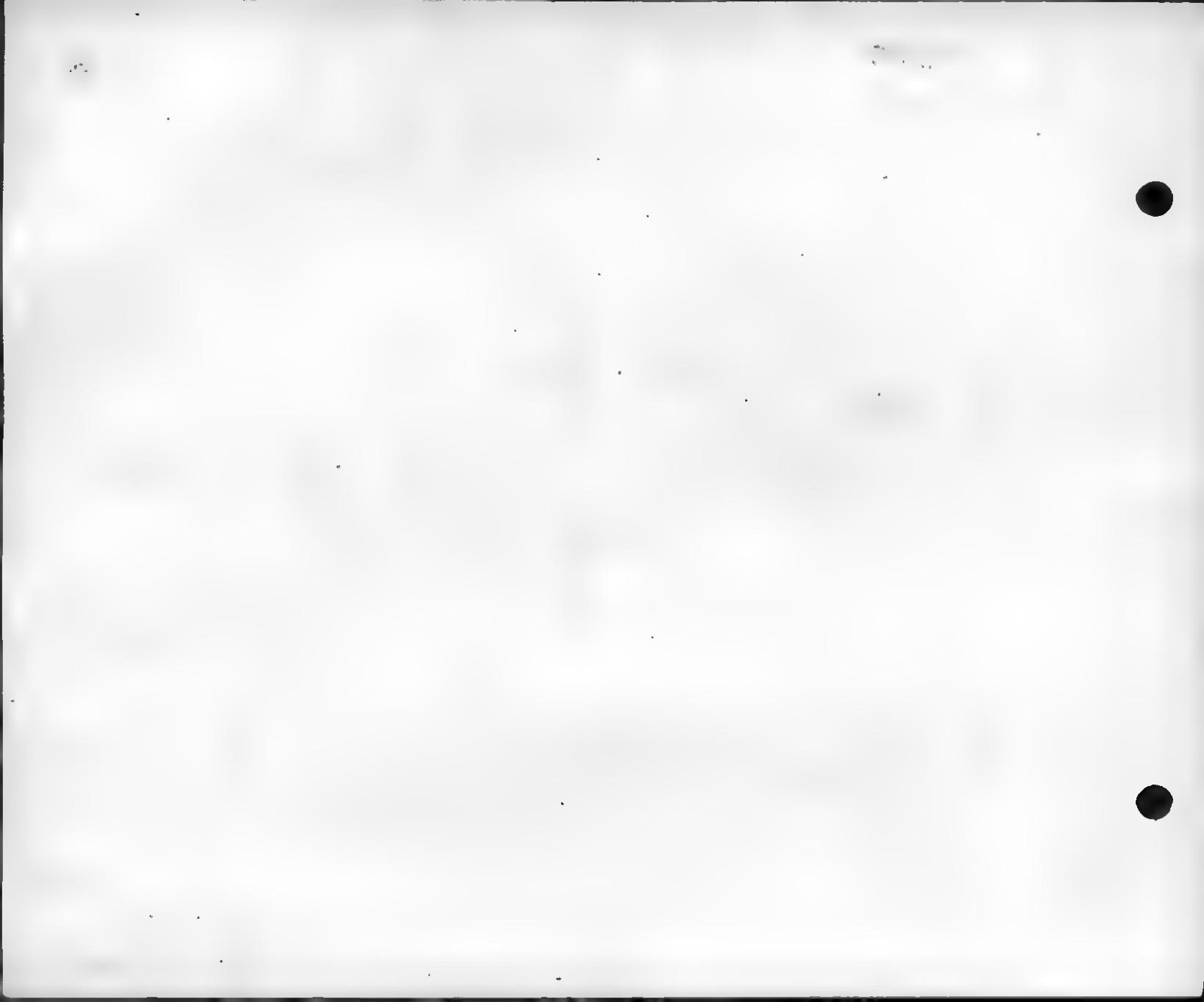
06198

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

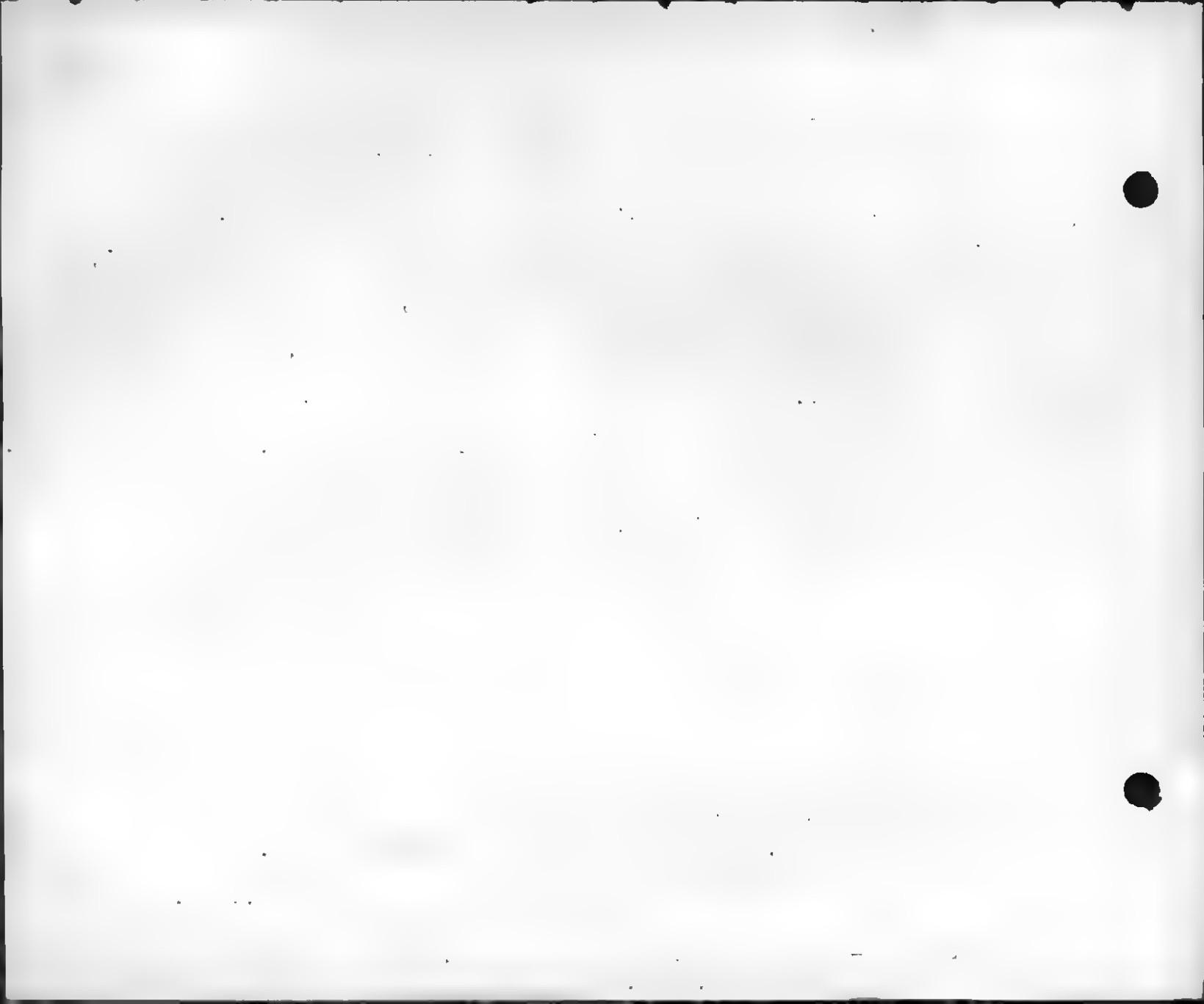
1. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAINDALE TOWNSHIP		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. COUNTY GEN. HOSP		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
3. NAME OF DECEASED (Type or print) ORVILLE		First W.	Middle BENEDICT
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12/13/81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Chief Inspector Balto. Commerce		10b. KIND OF INDUSTRY Chamber of Commerce	9. AGE (In years lost birthday) 85 yrs
13. FATHER'S NAME Jared D. BENEDICT		14. MOTHER'S MAIDEN NAME Rose Van Gundy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Carmelite B. Benedict same address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 143X (b) DUE TO H CVD ; CHF (c)		INTERVAL BETWEEN ONSET AND DEATH 11 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) DIABETIS MELLITUS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/15/67 , 19, to 5/15/67 , 19, that (I) (we) last saw the deceased alive on 5/11/67 , 19, and that death occurred at 8:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Gerald Maggid		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/11/67
22c. PHYSICIAN'S NAME (Type) GERALD MAGGID		22d. ADDRESS BALTO. COUNTY HOSP	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dulaney Valley Memorial Cemet.
24. FUNERAL DIRECTOR Wm. J. Chapman & Sons		25a. ADDRESS Baltimore Md.	25b. REC'D BY REGISTRAR DATE MAY 16 1967
			REGISTRAR'S SIGNATURE Charles J. Hogan



1
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
Item #13814 File #3309 6/21/67 p.CERTIFICATE OF DEATH Item 2 Film 0309 6/21/67											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
								a. STATE Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY Baltimore			
Baptist Home of Maryland				Baltimore				Baltimore			
3. NAME OF DECEASED (Type or print)		First Annie	Middle Lee	Last Bennett	4. DATE OF DEATH	Month May	Day 19, 1967	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1864				9. AGE (In years last birthday) 103 yrs.	f. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Richmond, Va.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Albert C. Bennett			14. MOTHER'S MAIDEN NAME Margaret Glazebrook								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.			17. INFORMANT			Address Baptist Home of Md. Owing's Mills, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure											
DUE TO (b) Arteriosclerotic C-V Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Senility											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan., 1960, to May 19, 1967, that (I) (we) last saw the deceased alive on May 19, 1967, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE M. Paul Byerly											
22c. PHYSICIAN'S NAME (Type) Dr. M. Paul Byerly			22b. DATE SIGNED 22d. ADDRESS 5820 York Rd.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 5/23/67			23c. NAME OF CEMETERY OR CREMATORIAL Baltimore			23d. LOCATION (City, town or county) Balto., Md. (State)		
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home						ADDRESS 6500 York Rd.			25a. REC'D BY REGISTRAR MAY 23 1967		
Balto., Md. 21212									25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

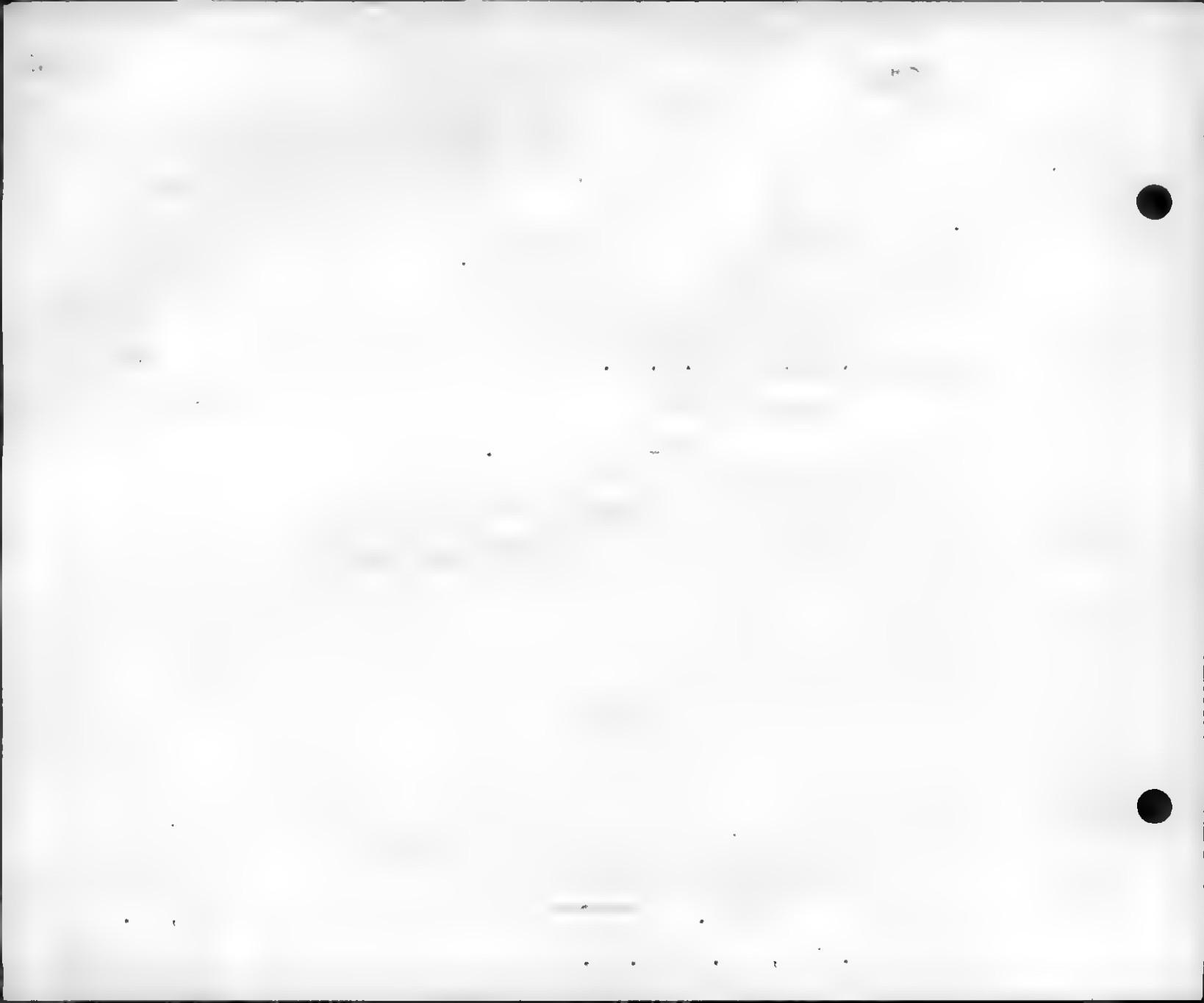
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers pages 1 and 2 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	c LENGTH OF STAY IN 1b 45 yrs.	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	d STREET ADDRESS 2717 Westfield Ave.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Sarah	First Sarah	Middle E.	Last Bewick
4 DATE OF DEATH 5	Month 5	Day 21	Year 1967
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH 1/8/1899	9 AGE (In years last birthday) 68	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS. Days 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator	10b. KIND OF BUSINESS OR INDUSTRY G.E. Co.	11. BIRTHPLACE (County & State, or foreign country) England	
13. FATHER'S NAME Richard Jennings		14. MOTHER'S MAIDEN NAME Catherine German	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No	16. SOCIAL SECURITY NO. 217-12-9881A	17. INFORMANT Mrs. Dorothea Hersey	Address (Same)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Renal insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) terminal stage of multiple myeloma DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Hypostatic pneumonia			19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4/25/	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/25/ , 19 67 , to 5/21 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/21 , 19 67 , and that death occurred at 8:25 PM , from causes and on the date stated above			
22a. SIGNATURE <i>Reynaldo Orjuela-Gomez</i>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.	22d. ADDRESS 7620 York Rd., Towson, Md. 21204		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/25/67.	23c NAME OF CEMETERY OR CREMATORIUM Ruckwood Parkwood Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	25a REC'D. BY REGISTRAR DATE MAY 24 1967
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

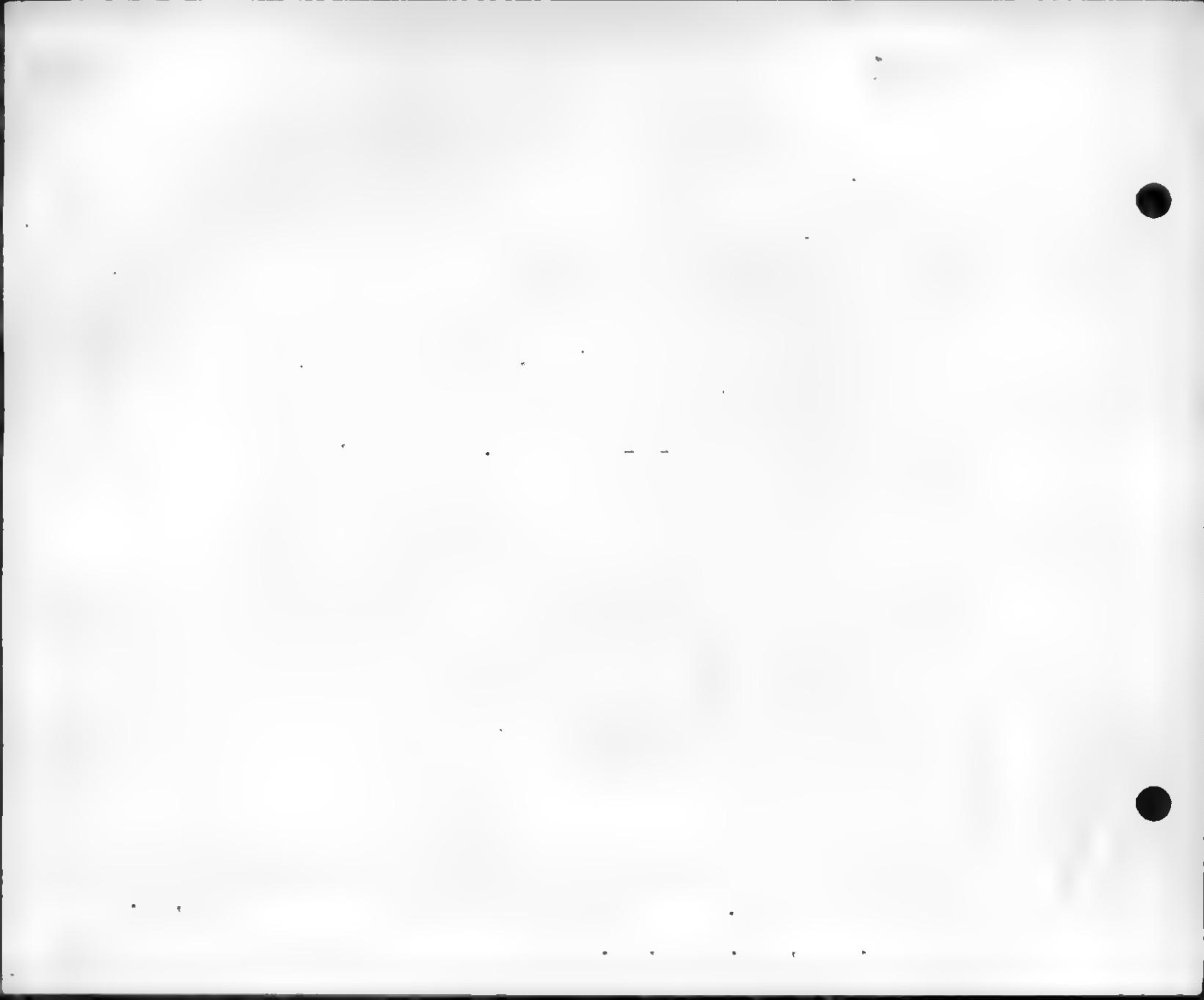
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06211

CERTIFICATE OF DEATH

06201

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit.) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 5853 Belair Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Henry Bilzer	First John	Middle Henry	Last Bilzer
4. DATE OF DEATH Month May	Month May	Doy 21	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 9-22-01		9. AGE (In years last birthday) 65 yrs	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edward Bilzer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>) No		16. SOCIAL SECURITY NO 214-01-9329A	
17. INFORMANT Mrs. Mary Bilzer		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Occlusion, left coronary artery. stating the underlying cause (c) Arteriosclerosis, generalized.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) April 8, 1967, to May 21, 1967, at
20f. (City or town) May 21, 1967		(County) (State)	
21. I certify that XX (this hospital) attended the deceased from April 8, 1967 , to May 21, 1967 , that XX (we) last saw the deceased alive on May 21, 1967 , and that death occurred at 4:55 AM , from causes and on the date stated above.			
22a. SIGNATURE Cockburn		22b. DATE SIGNED May 21, 1967	
22c. PHYSICIAN'S NAME (Type) Manuel S. Cockburn, M.D.		22d. ADDRESS 7620 York Road, Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67.	23c. NAME OF CEMETERY OR CREMATORIUM Holy redeemer Cemetery
23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. ADDRESS ADDRESS	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/66		25c. REC'D BY REGISTRAR MAY 22 1967	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

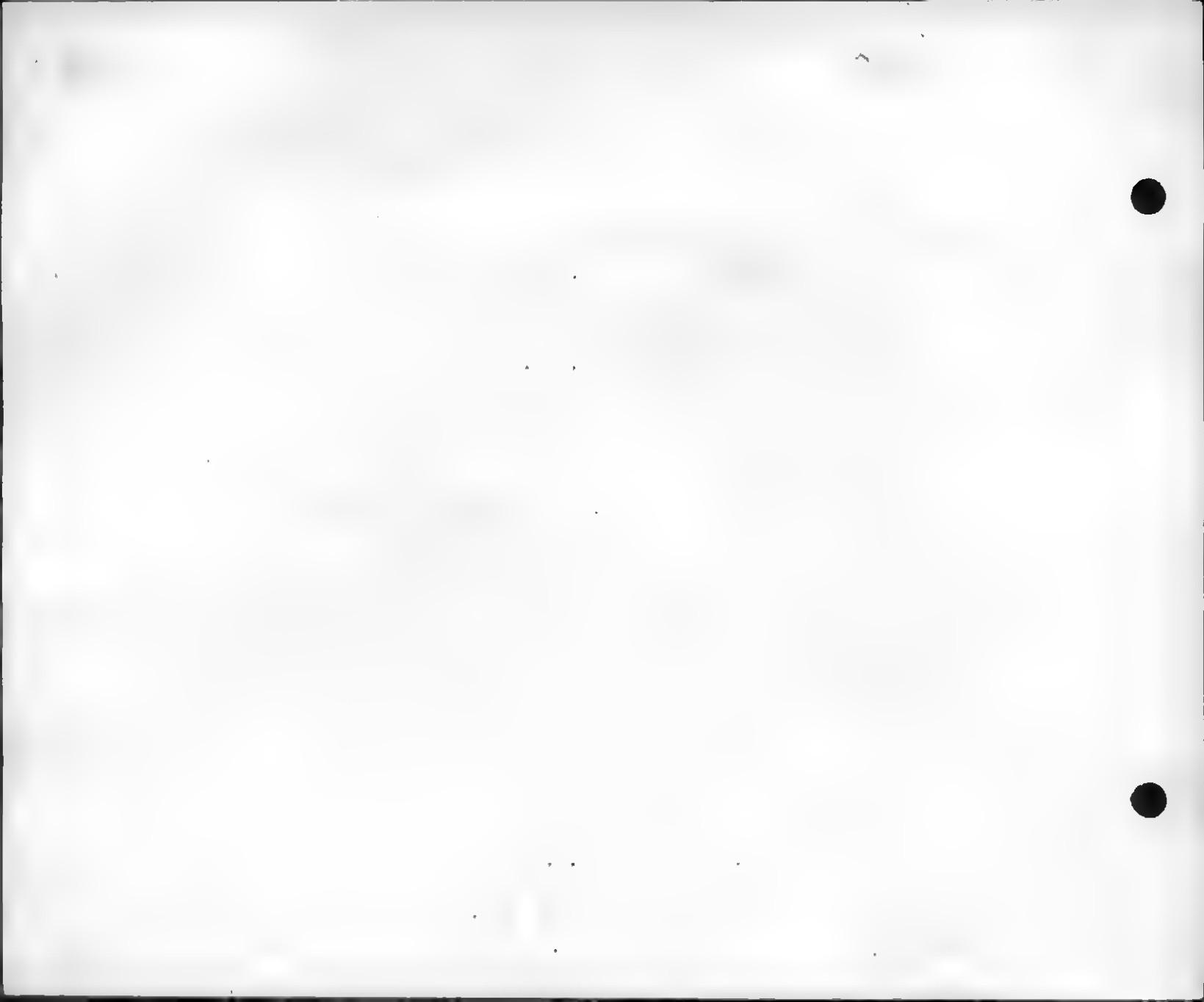
06212

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06202

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Pennsylvania		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN b b		d CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDonald,	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center			d STREET ADDRESS Rural		
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)		First WILLIAM	Middle A.	Last BISH	4 DATE OF DEATH Month May Day 4 , Year 19 67
S SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/28/16		9 AGE (In years last birthday) 51 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b KIND OF BUSINESS OR INDUSTRY GENERALCON. CO.		11 BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13 MOTHER'S NAME CLARENCE BISH			14 MOTHER'S MAIDEN NAME ETHEL WITSON		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIA. SECURITY NO		17 INFORMANT MARY BISH, MCDONALD, PA.	
Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO (c) Dissecting aneurysm of aorta					
INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm factory, street off e bldg etc.) 20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles S. Springate</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED May 5, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/8/67		23c NAME OF CEMETERY OR CREMATORIUM MIDIVAY CEM.	
23d LOCATION (City or Town) MIDIVAY, PA.		23e (County) (State)			
24 FUNERAL DIRECTOR HOWARD H. HUBBARD		ADDRESS 4107 WILKENS AVE. 21229		25a REG'D BY REGISTRAR MAY 8, 1967	
				25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

36213

CERTIFICATE OF DEATH

Reg. Dist. No. 3003

1. PLACE OF DEATH a. COUNTY BALTO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut dñ Residence before admission) a. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN PINES CONV. HOME		d. STREET ADDRESS 4457 SCOTIA Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maggie STREAGLE		First	Middle	Last	4. DATE OF DEATH May 21 1967
S. SEX 7	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/88	9. AGE (In years last birthday) 79 yrs	Month IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GLOUCESTER, VA.	
13. FATHER'S NAME EUGENE STREAGLE		14. MOTHER'S MAIDEN NAME MAEVE DUNSTON		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO		17. INFORMANT HARRY EMERSON Address 217200160	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Generalized Abdominal Carcinoma				INTERVAL BETWEEN ONSET AND DEATH 5 mo	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma of Transverse Colon				Unknown.	
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to May 21, 1967 , that I last saw the deceased alive on May 9, 1967 , and that death occurred at 5:30 AM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) Brandy Laughterty M.D. 1269 Frances Ave Baltimore Md 21217					
DATE SIGNED 5-21-67					
ACTUAL SIGNATURE Brandy Laughterty		PHYSICIAN'S NAME (Type) M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/24/67		22c. NAME OF CEMETERY OR CREMATORIUM BELLAMY CEMETERY	
22d. LOCATION (City, town, or county) GLoucester, VA.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE BRIDGES FUNL. HOME		ADDRESS Gloucester, VA.		24a. REG'D BY REGISTRAR DATE MAY 22 1967	
24b. REGISTRAR'S SIGNATURE Charles Judge					
P.T. 1967 Death Certificate Catonsville Md					

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be used for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

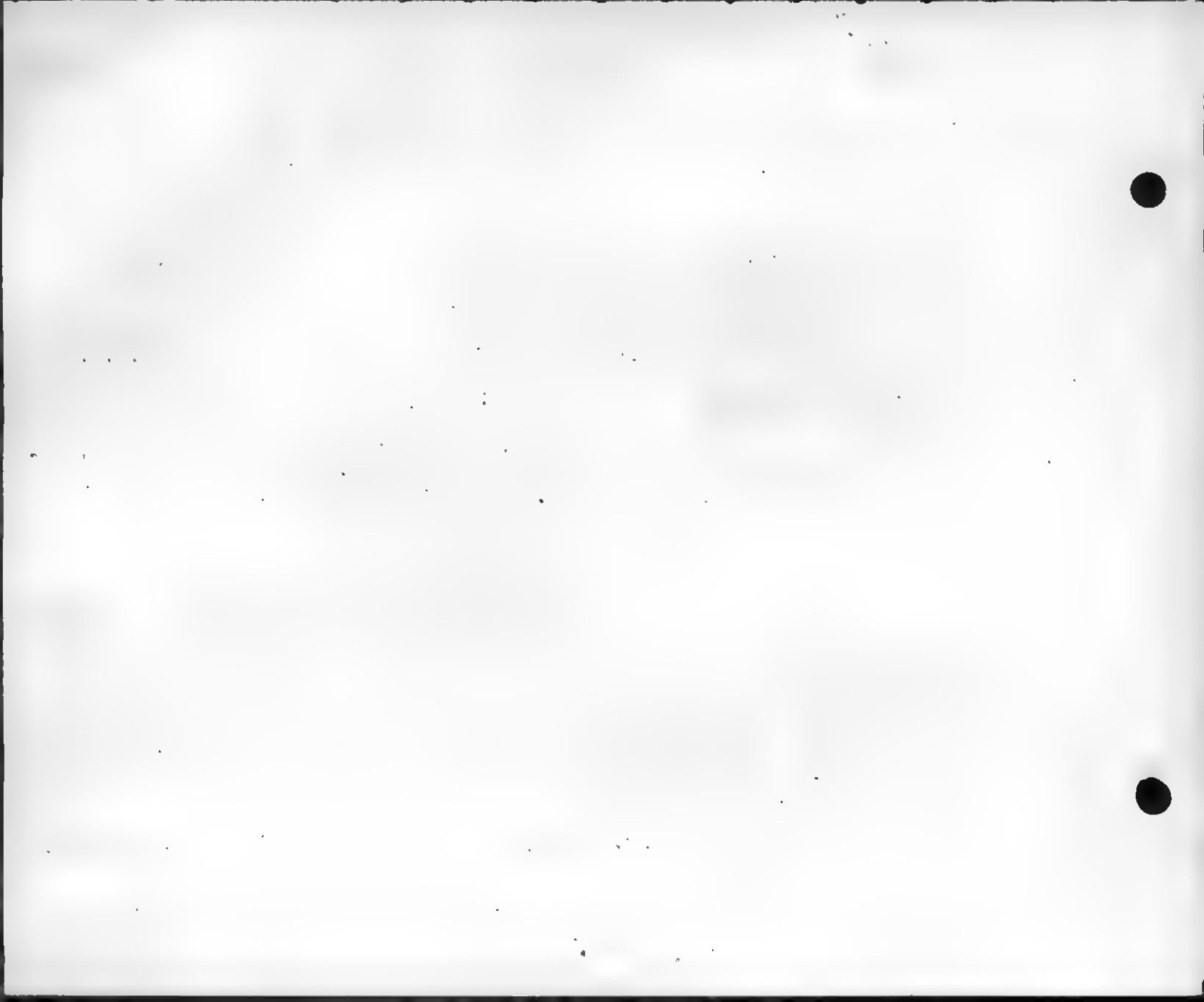


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												18304		
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
Baltimore MARYLAND			a. STATE Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Govans) Baltimore 12			b. COUNTY											
c. LENGTH OF STAY IN 1b 26 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Govans)											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 322 Regester Avenue			d. STREET ADDRESS 322 Regester Avenue											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			First ALICE	Middle MONA	Last BOLLINGER	4. DATE OF DEATH	Month May	Day 17,	Year 1967					
5. SEX female			6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1908	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY housewife			11. BIRTHPLACE (County & State, or foreign country) Carroll County			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles L. Brauning			14. MOTHER'S MAIDEN NAME Mollie Shipley			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT J. Wilbur Bollinger Address 322 Regester Ave Baltimore 12, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Bronchial Pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH 5 hrs.								
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) _____ DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>May 15, 1967</i> to <i>May 11, 1967</i> , that (I) (we) last saw the deceased alive on <i>May 16, 1967</i> , and that death occurred at <i>10:45 AM</i> , from the causes and on the date stated above.												22b. DATE SIGNED		
22a. SIGNATURE <i>Theodore G. de Cueredo</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <i>Theodore G. de Cueredo</i>			22d. ADDRESS <i>223 Thornhill Rd. Bethesda, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>			23b. DATE THEREOF <i>5/20/67</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Providence Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Finksburg RD, Maryland</i>					
24. FUNERAL DIRECTOR <i>J. E. Myers, Jr., Mortician, Md.</i>			ADDRESS			25a. REC'D BY REGISTRAR <i>MAY 22, 1967</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06215

CERTIFICATE OF DEATH

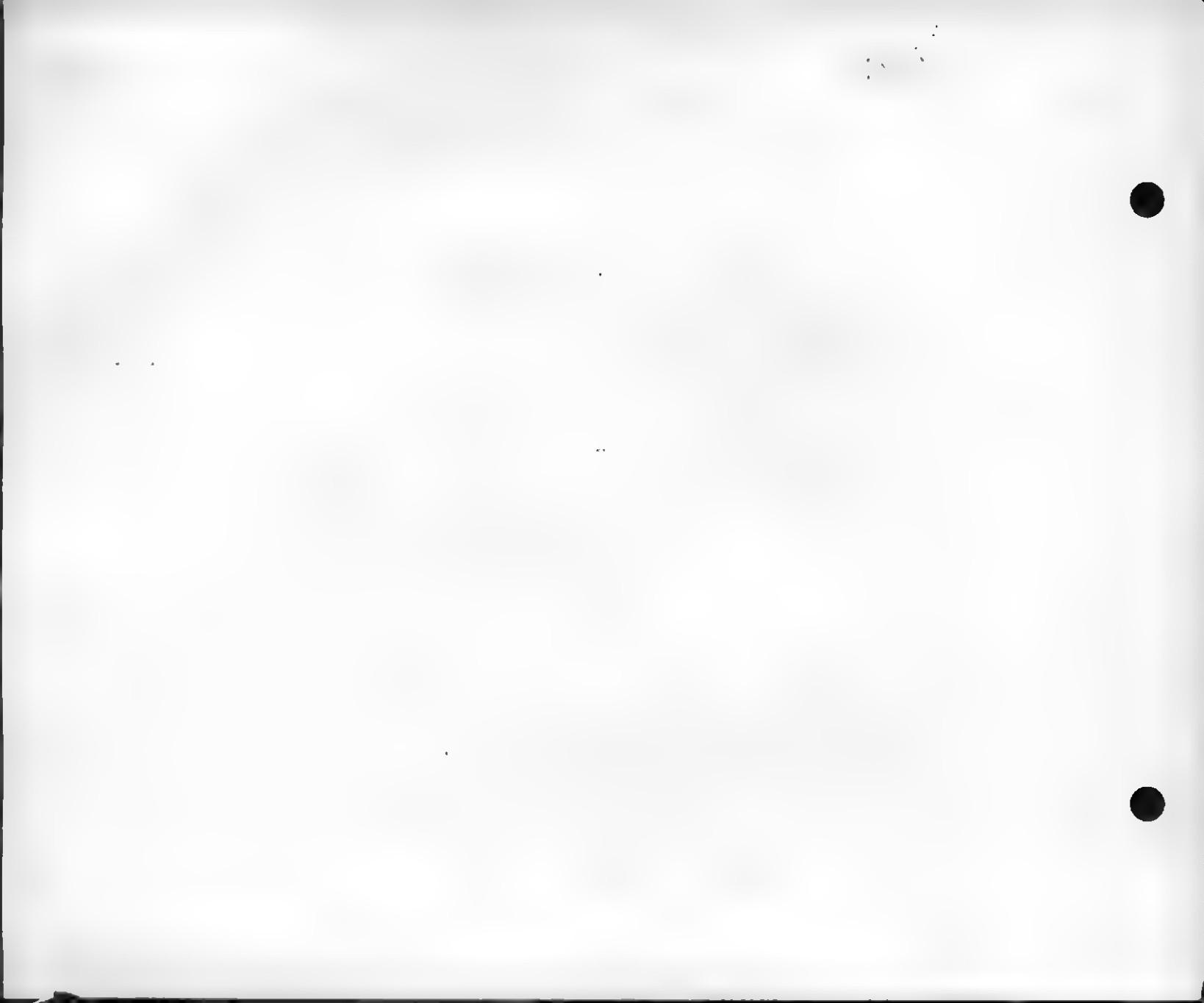
Items #8, 9, 16, 23a, b
 Form 1389, 5/1/67, pub.

15205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville		c. LENGTH OF STAY IN lb 2yr7mth18days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First George Middle G. Last Bookhultz		4 DATE OF DEATH MAY 24 1967	
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/94 June 8, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		9. AGE (In years last birthday) 72 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service		16. SOCIAL SECURITY NO 2315-03-2622	
		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Arteriosclerotic cardiovascular disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c)			
Arteriosclerotic cardiovascular disease			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oct. 6
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-24, 1967, to 5-24, 1967, that (I) (we) last saw the deceased alive on 5-24, 1967, and that death occurred at 6:15 P.M., from causes and on the date stated above.			
22a. SIGNATURE Morris Meiller		22b. DATE SIGNED 5/24/67	
22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial, Cremation		23b. DATE THEREOF May 22, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Farley - Cavanaugh		ADDRESS 6601 Frederick	25a. REC'D BY REGISTRAR DATE MAY 29 1967
		25b. REGISTRAR'S SIGNATURE Charles Jones	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

06216

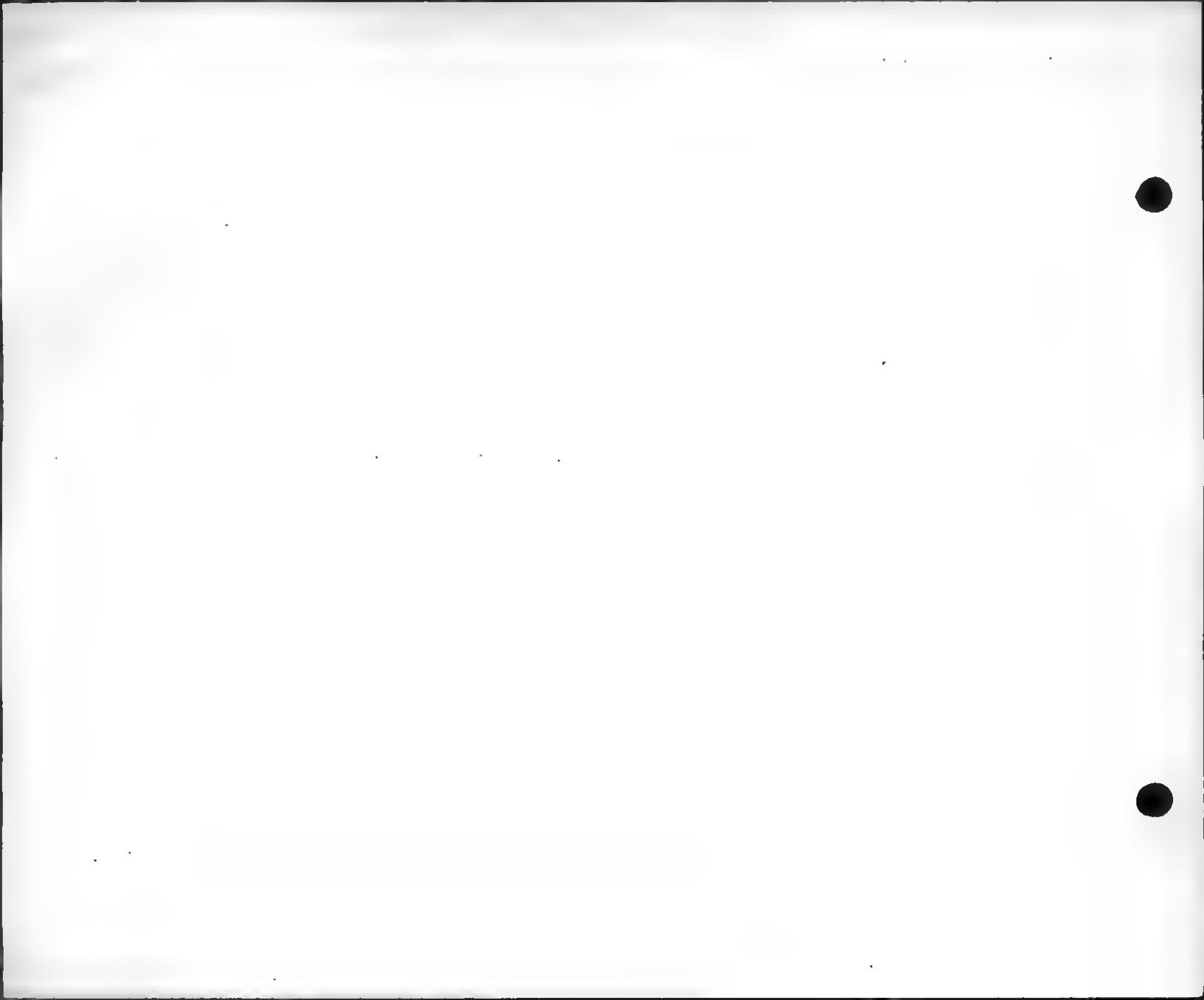
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06216

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay in delivery of the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE M.D. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c LENGTH OF STAY IN TB d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PINE RIDGE GOLF COURSE		d STREET ADDRESS 4312 BARRINGTON RD. 2122 9	
3 NAME OF DECEASED (Type or print) LOUIS Charles		First B	Middle ORCHERDING, Jr.
4 DATE OF DEATH MAY 30 1967		Lost	Month
S SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 6/7/03
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 AGE (In years last birthday) 63 yrs
10a USCL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Proctor & Gamble	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Louis C. Borcherding, Sr.		14 MOTHER'S MAIDEN NAME Bertha Kuhlow	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) No		16 SOCIAL SECURITY NO 214-01-8979	
17 INFORMANT Mrs. Helen R. Borcherding Barrington Rd.		Address 4312	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)		DUE TO MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) Baltimore (County) M.D. (State) M.D.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Towson, Md.	
22. DATE SIGNED 5/30/67			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 6/2/67	23c NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery
24 FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229		23d LOCATION (City or Town) Baltimore, Maryland (County) M.D. (State)	
		25a REC'D BY REGISTRAR DATE JUN 2 1967	25b REGISTRAR'S SIGNATURE By Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06217

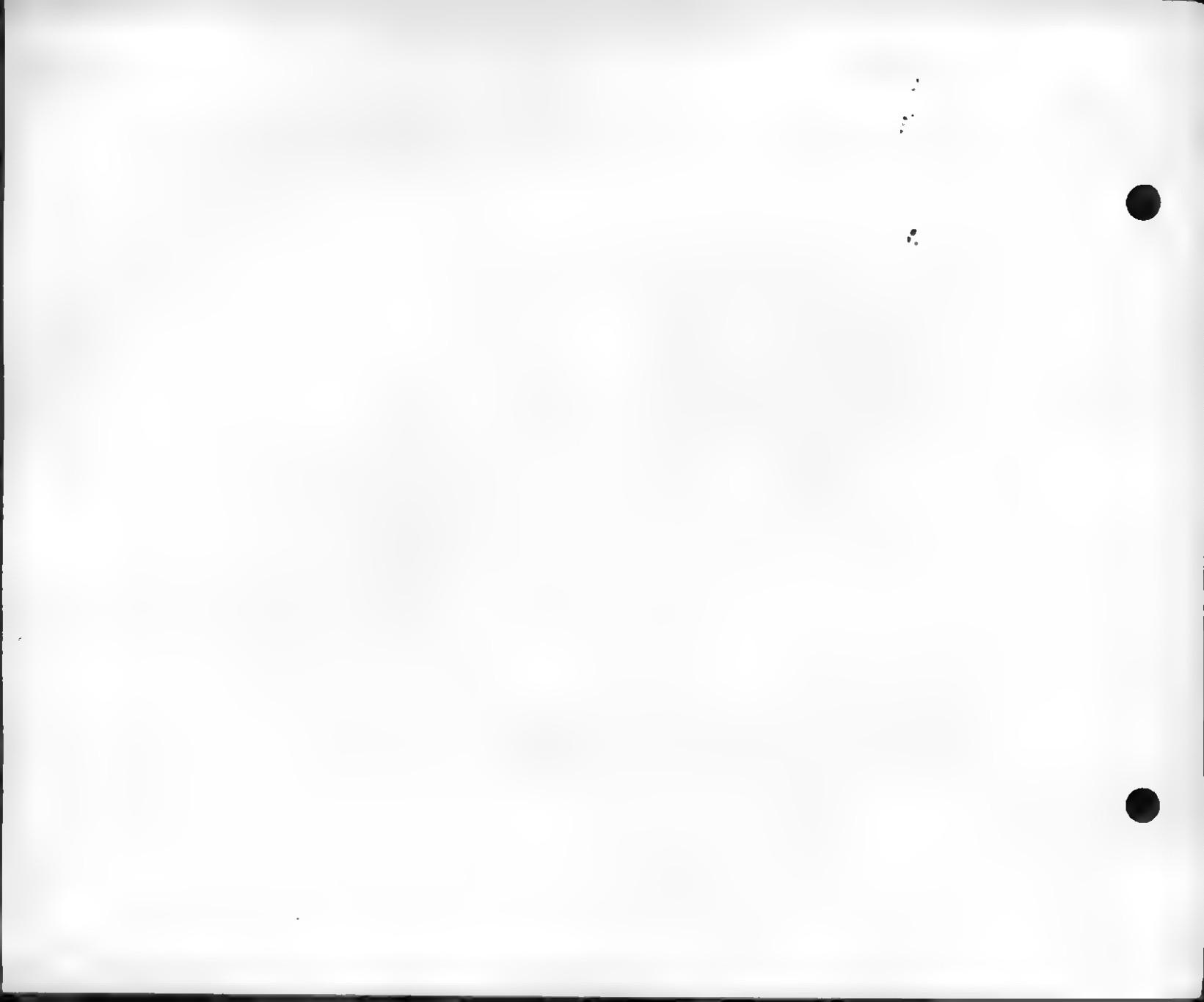
CERTIFICATE OF DEATH

06208

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTO			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN lb		b. COUNTY BALTO	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT HOME			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN 21207		
3 NAME OF DECEASED (Type or print) JOHN BERNARD BREITENBACH			4 DATE OF DEATH Month Day Year 5/19 1967		
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 4/4/1911	9. AGE (In years from last birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) RET.			10b KIND OF BUSINESS OR INDUSTRY B.Y.O. R.R.	11. BIRTHPLACE (County & State, or foreign country) Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME RUDOLPH BREITENBACH			14. MOTHER'S MAIDEN NAME LOUISE HENNEGIR		
15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Address FRANKLIN R. BREITENBACH	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA PLEURIS, LEFT INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ last. (c) _____					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) BALTO	(County) Md (State)
21. I certify that (I) (this hospital) attended the deceased from 2/10/1966 to 2/19/1967 that (I) (we) last saw the deceased alive on 5/8/1967 , and that death occurred at 924 M. from causes and on the date stated above.					
22a. SIGNATURE Thos E. Roach		22b. DATE SIGNED 5/10/67			
22c. PHYSICIAN'S NAME (Type) Thos E. Roach		22d. ADDRESS 5550 BALTO VAT 2 Line			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/12/67	23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK	23d. LOCATION (City or Town) (County) (State) BALTO Md.	
24. FUNERAL DIRECTOR E. S. MACNABB		ADDRESS 301 FREDERICK RD 21228	25a. REG'D BY REGISTRAR DATE MAY 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

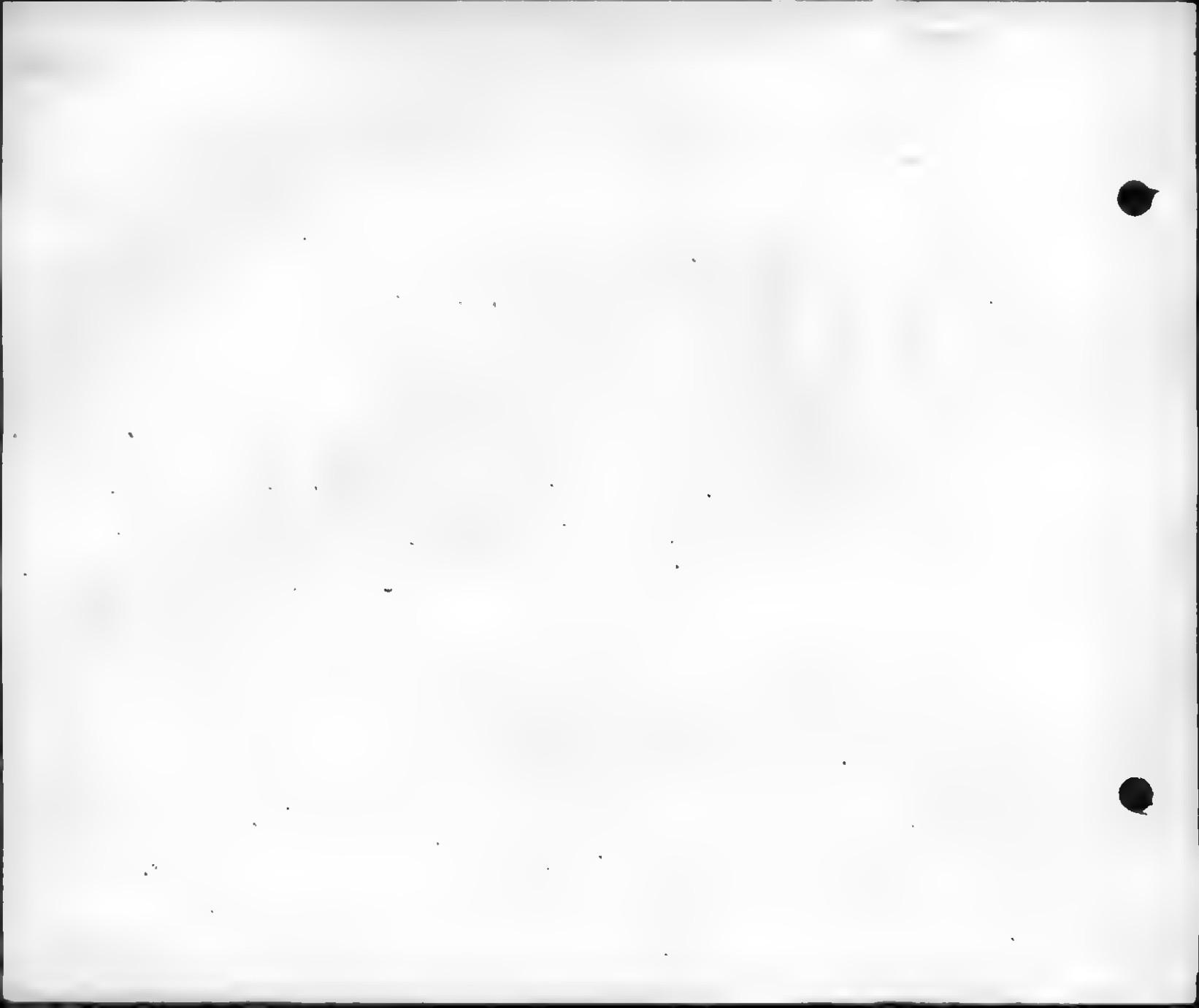
CERTIFICATE OF DEATH

Reg. Dist. No.

06218 06209

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)		
				a. STATE	Maryland	
b. C.TY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	Baltimore	
Rural-Rosedale		10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1328 Evening Avenue		d. STREET ADDRESS		
				1328 Evening Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	
Christine G. Brewer					May 20 Month Day Year	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years at birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
Female	White		Dec. 1, 1907		59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife				Maryland		USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Joseph Levy		Elizabeth				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address
No		218 09 1275		Chrystelle Brockmeyer		2220 Jaycee Dr. Joppa, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a))						
acute myocardial failure						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) & (c)						
INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
sudden						
DUE TO						
Arteriosclerotic Cardio-Vascular disease 10 yrs						
DUE TO						
Diabetes mellitus 15 yrs						
DUE TO						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) & (c)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
Hour o. m. p. m.		19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21. I certify that I attended the deceased from May 21, 1967, to May 26, 1967, that I last saw the deceased alive on May 26, 1967, and that death occurred at 1 AM, from the causes and on the date stated above.						
ADDRESS (Street, city or town, state)						
DATE SIGNED						
ACTUAL SIGNATURE						
Baltimore, Maryland						
G. M. BAUMGARDNER						
PHYSICIAN'S NAME (Type)						
May 22, 1967						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	(State)
Burial		May 22, 1967	Gardens of Faith Cemetery		Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
Philip G. Evans		1211 Chesaco Avenue		DATE	MAY 22, 1967 Charles Judge	



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-33 and 37. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06219

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06210

1. PLACE OF DEATH COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Essex House Tavern			d. STREET ADDRESS 446 Eastern Avenue		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First HERBERT	Middle RICHARD	Last BRODNICK	4. DATE OF DEATH 5	Month 3
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 36 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR			10b. KIND OF BUSINESS OR INDUSTRY ESTERN TAXI CAB CO.		
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME BENJAMIN BRODNICK			14. MOTHER'S MAIDEN NAME ELIZABETH FISHER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO UNKNOWN		
17. INFORMANT MR. LOUIS BRODNICK, 3921 BANCROFT ROAD			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cor pulmonale			INTERVAL BETWEEN ONSET AND DEATH		
Cond tions, if any which gave use to immediate cause (a), stating the underlying cause Obesity - (Pickwickian Syndrome)					
DUE TO 287V					
DUE TO Cond tions, if any which gave use to immediate cause (a), stating the underlying cause Obesity - (Pickwickian Syndrome)					
DUE TO lost					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. - 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>R.S. Fisher</i> EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		
22. DATE SIGNED 5-3-67			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/4/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS CHER SHALOM	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

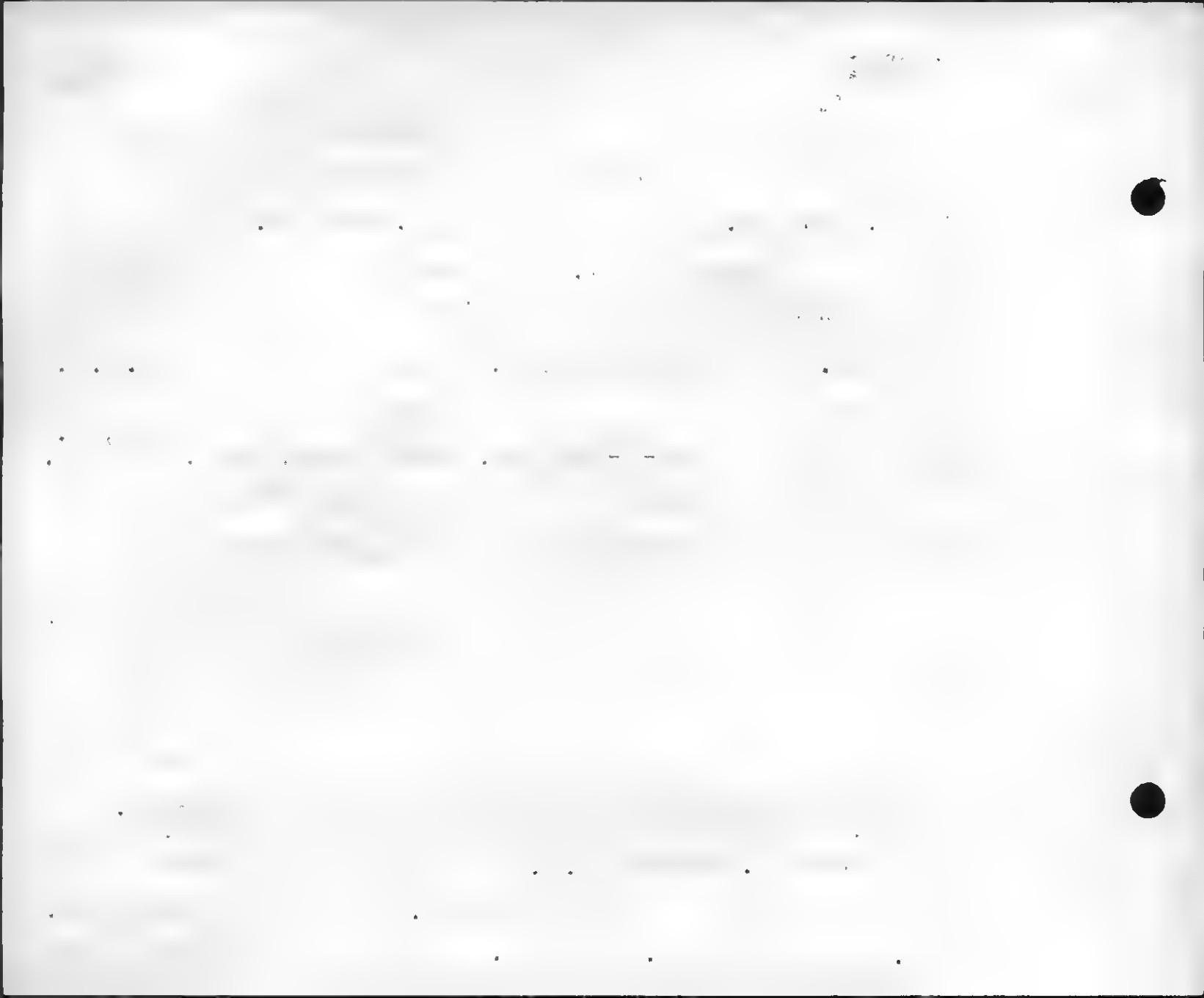
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06220

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26211

1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		b COUNTY Baltimore	
c LENGTH OF STAY IN lb 21 Years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2523 S. Snyder Ave.		d STREET ADDRESS 2523 S. Snyder Ave.	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Venton	Middle J.	Last Brooks
4 DATE OF DEATH	Month May	Day 16	Year 1967
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/1/15
9 AGE (In years last birthday) 52	10 IF UNDER 1 YEAR Months 0	11 BIRTHPLACE (State or foreign country) Virginia	12 CITIZEN OF WHAT COUNTRY? U. S. A.
10a LSELAL OCCUPATION (Give kind of work done during most of working life, even retired) Scale Dept.	10b KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	13 FATHER'S NAME David Brooks	14 MOTHER'S MAIDEN NAME Clevie Brooks
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16 SOCIAL SECURITY NO 217-07-7081	17 INFORMANT (Wife) Mrs. Florence Brooks, 2523 S. Snyder Ave.	Address Edgemere, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) (c)	INTERVAL BETWEEN ONSET AND DEATH Chronic Coronary Occlusion Hypertension Cardiowascular Disease		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic Obstruction by History			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.		
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) Baltimore	(County) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Theodore C. Patterson</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 105 Main St.		
EXAMINER'S NAME (Type) Theodore C. Patterson M. D.	22. DATE SIGNED Dundalk, Maryland		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/19/67	23c NAME OF CEMETERY OR CREMATORIUM Gardens of Faith Cem.	23d LOCATION (City or Town) Baltimore, Md.
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.	ADDRESS	25a REC'D BY REGISTRAR MAY 18 1967	25b REGISTRAR'S SIGNATURE <i>John J. Duda</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06221

CERTIFICATE OF DEATH

IC212

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. *Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.*

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 64 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d STREET ADDRESS 1408 N. MOUNT STREET		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) FRANK VERNON BROWN		4 DATE OF DEATH MAY 5 1967	Month Day Year
S SEX MALE	6 COLOR OR RACE NEGRO	7. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 6, 1907
10a JUSICAL OCCUPATION (Give kind of work done during most of working life, even if retired) RIGGER		10b KIND OF BUSINESS OR INDUSTRY SHIP YARD	
11 BIRTHPLACE (County & State, or foreign country) LITTLETON, N. C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK BROWN		14. MOTHER'S MAIDEN NAME MARTHA HAWKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		6 SOCIAL SECURITY NO 213 09 12 91	17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5811		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b)		UNKNOWN	
DUE TO (c)		UNKNOWN	
LAENNEC'S CIRRHOSIS			
CHRONIC ALCOHOLISM			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HEART DISEASE (HYPERTROPHY) UNKNOWN ETIOLOGY			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) VAH FORT HOWARD, MARYLAND
20f (City or town) (County) (State)			
21. I certify that (I)(this hospital) attended the deceased from 3/2/67 , 19 to 5/5/67 , 19, that (we) last saw the deceased alive on 5/5/67 , 19, and that death occurred at 6:30A M, from causes and on the date stated above			
22a. SIGNATURE <i>Neilon B. Bailey, Jr.</i>		22b. DATE SIGNED 5/5/67	
22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, N. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-9-67	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore NATIONAL
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Nelson B. Bailey, Jr.</i>		25a. ADDRESS KELSON FUNERAL HOME N. CALHOUN ST. BALTIMORE,	25a. REC'D BY REGISTRAR MAY 9 1967
		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												06213		
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Baltimore			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN 1b 16 Years			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			b. COUNTY Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 133 Pleasant Hill Road									c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills					
3. NAME OF DECEASED (Type or print)			First Millie	Middle Catherine	Last Brown	4. DATE OF DEATH MAY 14 1967			Month MAY	Day 14	Year 1967	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX Female			6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/1880	9. AGE (in years last birthday) 87 yrs.			10. IF UNDER 1 YEAR Months 0	Days 0	Hours 0	11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Housework-Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home.			11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME David N. Bair			14. MOTHER'S MAIDEN NAME Anna Mary Myers											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 196-16-9926			17. INFORMANT 133 Pleasant Hill Rd., Mrs. Claude H. Miller Owings Mills, Md.			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA			INTERVAL BETWEEN ONSET AND DEATH 24 HRS		
DUE TO (b) ARTERIOSCLEROTIC C.V. DISEASE WITH CARDIAC DECOMPENSATION												YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from JUNE 1951 , to MAY 14, 1967 , that (I) (we) last saw the deceased alive on MAY 13 1967 , and that death occurred at 3:15 AM , from the causes and on the date stated above.												22b. DATE SIGNED May 14, 1967		
22a. SIGNATURE Martin E. Strobel			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) MARTIN E. STROBEL			22d. ADDRESS 48 MAIN ST. REISTERSTOWN MD											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/17/67			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Marys Cemetery Littlestown, Pa.			23d. LOCATION (City, town or county) (State) Silver Run, Carroll Co. Md.					
24. FUNERAL DIRECTOR Richard A. Little									25a. REC'D BY REGISTRAR DATE MAY 16 1967			25b. REGISTRAR'S SIGNATURE Charles Judge		

$T_{\mu\nu}$

$P_{\mu\nu}$

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

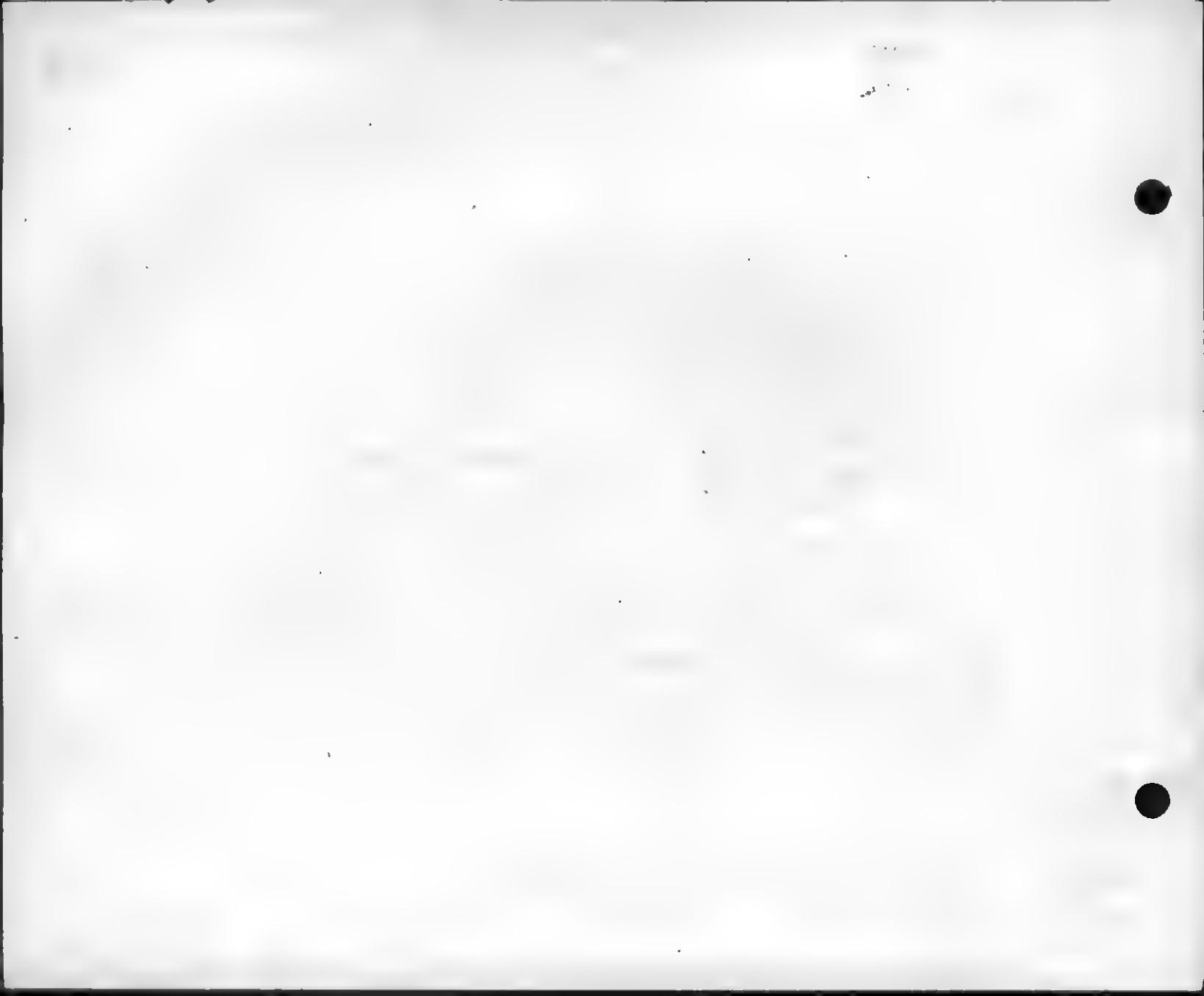
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 **15.** **06223** **06214**

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson			c. LENGTH OF STAY IN lb 2 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital			d. STREET ADDRESS 2027 Sinclair Lane		
e. NAME OF DECEASED (Type or print) WILLIE LEMMETT BROWN			f. DATE OF DEATH Month 5 Day 10 Year 1967		
g. SEX M	h. COLOR OR RACE Negro	i. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	j. NEVER MARRIED <input type="checkbox"/>	k. DATE OF BIRTH 12-12-1917	
l. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		l. 10b. KIND OF BUSINESS OR INDUSTRY		l. 11. BIRTHPLACE (County & State, or foreign country) Georgia	
l. 13. FATHER'S NAME LEMMETT BROWN			l. 14. MOTHER'S MAIDEN NAME EMMA BUTLER		
l. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No		l. 16. SOCIAL SECURITY NO 264-05-6125		l. 17. INFORMANT Address Records, Mount Wilson State Hospital	
l. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac tamponade INTERVAL BETWEEN ONSET AND DEATH 2 days DUE TO (b) Pericardial effusion 7 days DUE TO (c) Pulmonary inflammatory infiltrate 6 weeks					
l. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
l. 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		l. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
l. 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		l. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		l. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) l. 20f. (City or town) (County) (State)	
l. 21. I certify that (I) (this hospital) attended the deceased from 5-8 , 19 67 , to 5-10 , 19 67 , that (I) (we) last saw the deceased alive on 5-10 19 67 , and that death occurred at 5-10 A.M. , from causes and on the date stated above.					
l. 22a. SIGNATURE Wm. Newcomer		l. 22b. DATE SIGNED PM 5-10-1967			
l. 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		l. 22d. ADDRESS Mount Wilson, Maryland			
l. 23a. BURIAL, CREMATION, REMOVAL (Specify)		l. 23b. DATE THEREOF.		l. 23c. NAME OF CEMETERY OR CREMATORIAL	
l. 24. FUNERAL DIRECTOR		ADDRESS		l. 25a. REC'D BY REGISTRAR DATE MAY 12 1967	
				l. 25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

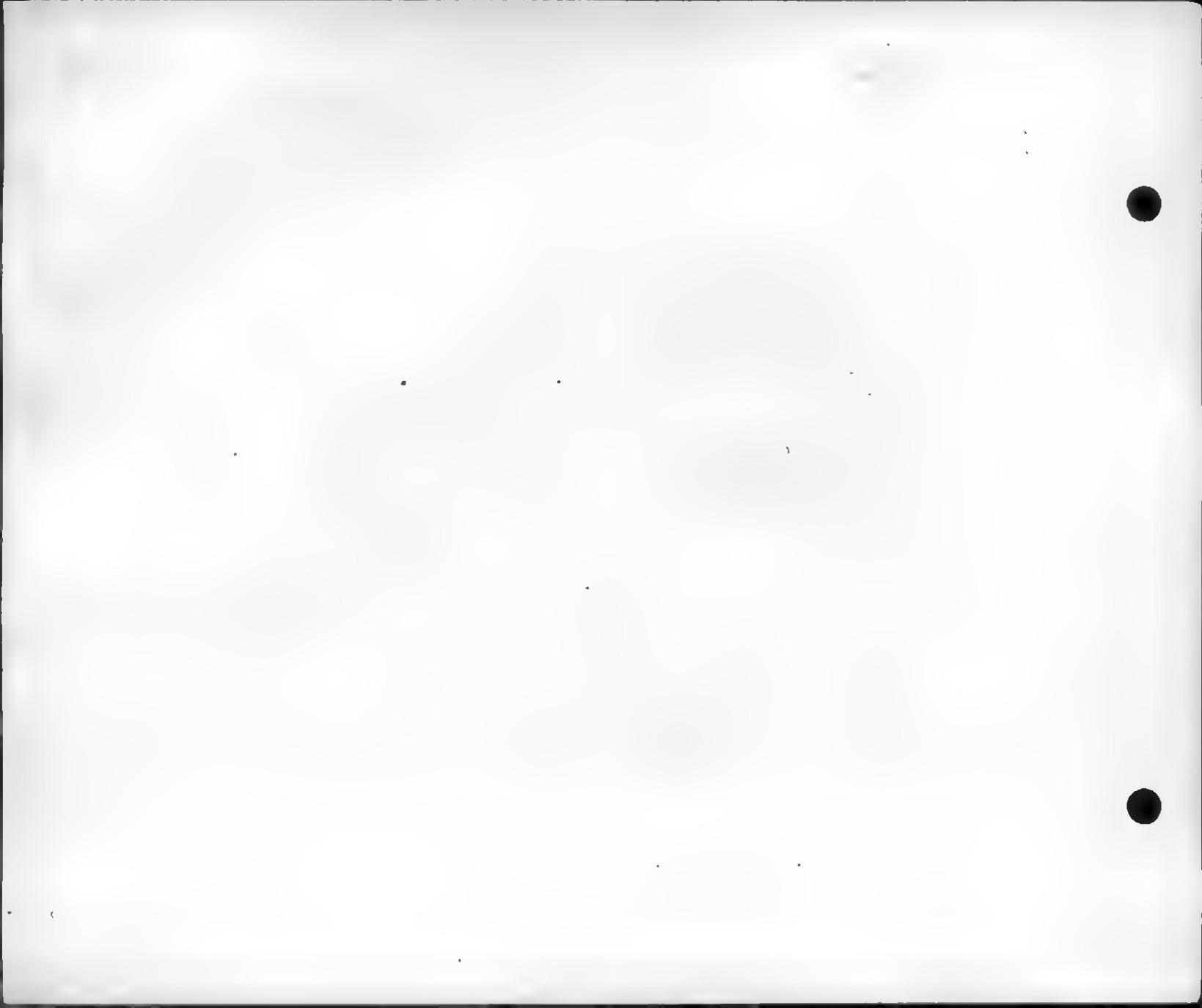
36224

CERTIFICATE OF DEATH

OC215

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE			MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE 21212				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			c. LENGTH OF STAY IN 16			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER.			d. STREET ADDRESS 214 HOPKINS ROAD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CHARLES MULLEN BURGEE			First	Middle	Last	4. DATE OF DEATH MAY 16 1967	Month	Day	Year	
S. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-95	9. AGE (In years last birthday) 71 yrs	10. KIND OF BUSINESS OR INDUSTRY Western Electric Co.	11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME XESSONG	14. MOTHER'S MAIDEN NAME XESSONG XXXX	S. rah Hessong
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN			16. SOCIAL SECURITY NO 216-01-9248			17. INFORMANT PT'S CHART	Address Mrs. Evelyn P.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO Post-operative irreversible shock (c) DUE TO Ruptured abdominal aortic aneurysm.			Burgee			INTERVAL BETWEEN ONSET AND DEATH				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) factory, street, office bldg., etc.	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from May 16, 1967 to May 16, 1967 , that (I) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 9:25 AM , from causes and on the date stated above										
22a. SIGNATURE Robert W. Smith M.D.			22b. DATE SIGNED 5-16-67							
22c. PHYSICIAN'S NAME (Type) Dr. Robert W. Smith			22d. ADDRESS Greater Baltimore Med. Center							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/20/67	23c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd.			ADDRESS Baltimore, Md. 21212			25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE MAY 23 1967			
VR A15 (4) 25M 1/67										



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06225

CERTIFICATE OF DEATH

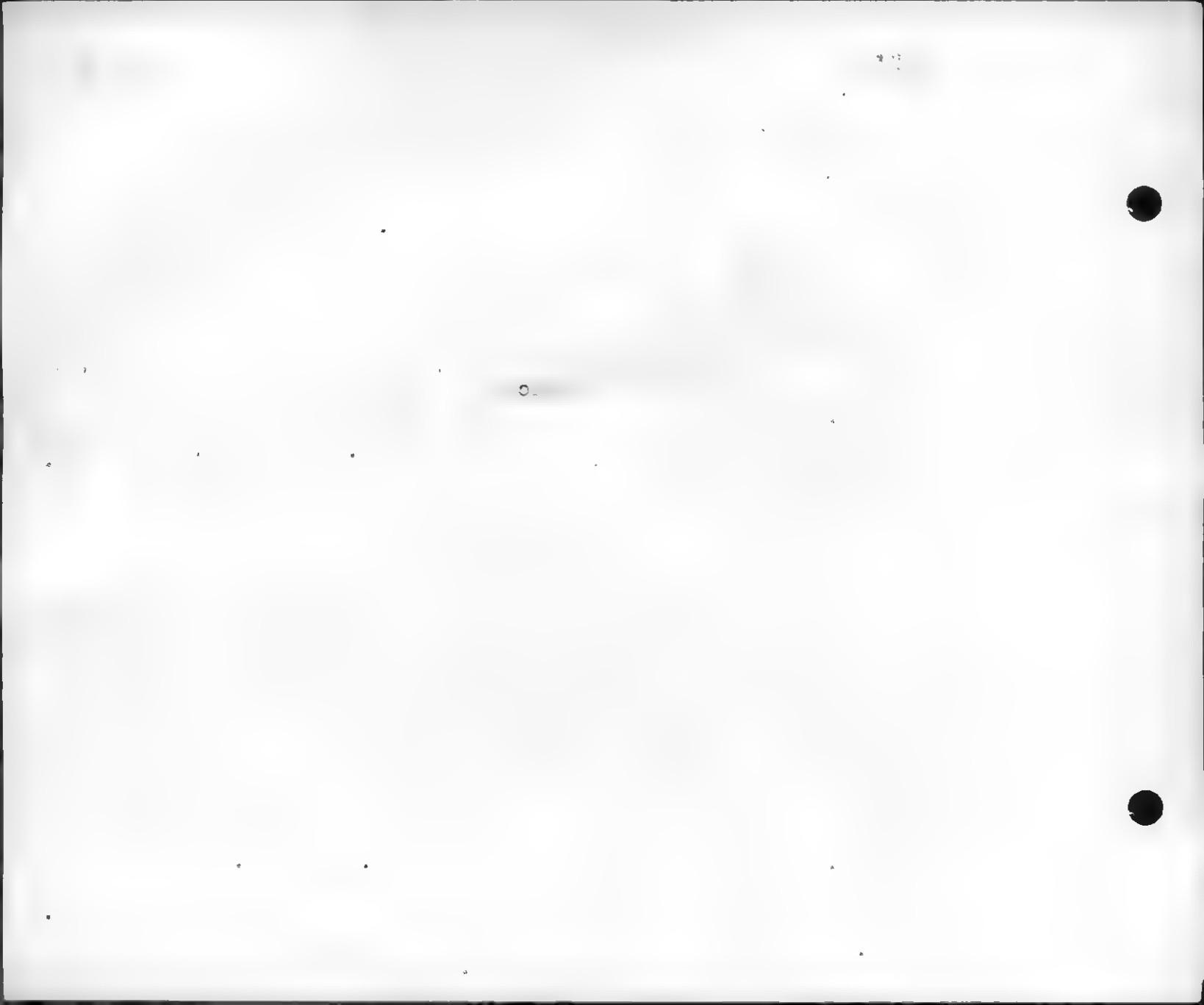
06216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		d. STREET ADDRESS 306 E. 32nd Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ella Cobb Bush		4. DATE OF DEATH Month Day Year May 24 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/83	
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 hours 0 Min. 0	
11. BIRTHPLACE (County & State, or foreign country) Johns Hopkins Hosp. Maryland		12. IF UNDER 24 HRS Hours 0 Min. 0	
13. FATHER'S NAME Albert H. Bush		14. MOTHER'S MAIDEN NAME Margaret Elizabeth Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220-30-2972	
17. INFORMANT Frederick J. Singley, Jr.		18. ADDRESS First Nat'l Bank Bldg.	
19. INTERVAL BETWEEN ONSET AND DEATH 4 days			
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)			
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item B)	
25. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		26. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.		30. SIGNATURE <i>Franklin E. Leslie</i>	
31. ATTENDING PHYS.		32. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
33. ADDRESS 302 E. 33rd St.		34. DATE SIGNED 5-25-67	
35. BURIAL, CREMATION, REMOVAL (Specify) Burial		36. DATE THEREOF 5/26/67	
37. NAME OF CEMETERY OR CREMATORIAL Greenmount		38. LOCATION (City or Town) (County) (State) Baltimore Md.	
39. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co		40. ADDRESS 4905 York Rd.	
41. REGISTRATION NUMBER 12		42. RECEIVED BY REGISTRAR MAY 26 1967	
43. DATE 1967		44. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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16226

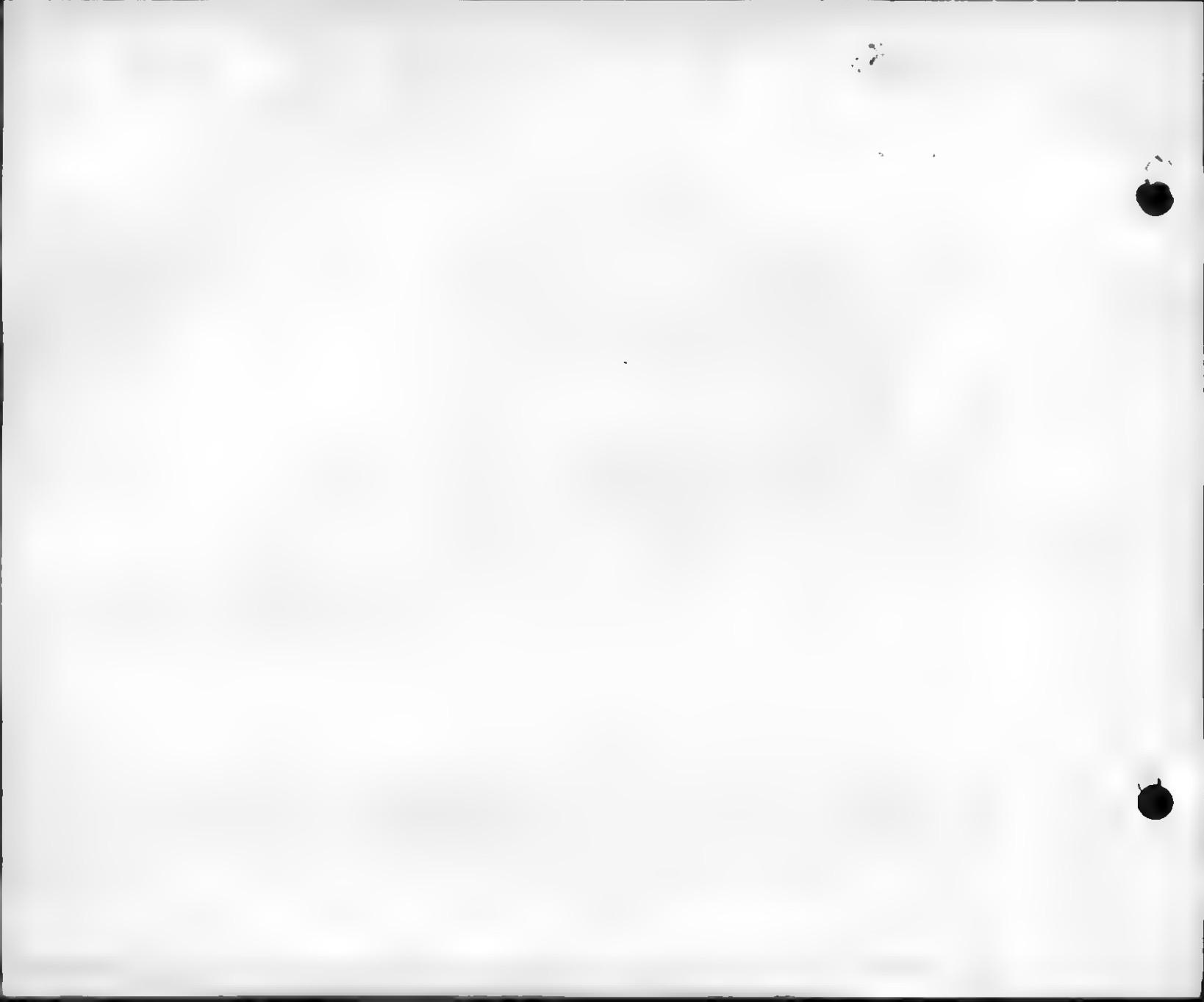
CERTIFICATE OF DEATH

05217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) d. STATE Maryland b. CO. JCTY. BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY HALL		c. LENGTH OF STAY IN lb 34 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9714 BELAIRE Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HENRY	Middle Anthony	Last BUTT
4. DATE OF DEATH	Month MAY	Day 7	Year 1967
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 9, 1897
8. AGE (In years lost birthday) 69 yrs.	9. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner	10b. KIND OF BUSINESS OR INDUSTRY HOTEL
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry S. Butt	14. MOTHER'S MAIDEN NAME Elizabeth Triskay		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT ?	Address Wilbert Gries 1735-W. Pratt St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right lung		INTERVAL BETWEEN ONSET AND DEATH months	
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 163X		(b) ✓	
DUE TO (c) ✓			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. May 7, 1967 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore		(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from April 1, 1967 , to May 7, 1967 , that (I) (we) last saw the deceased alive on May 7, 1967 , and that death occurred at Md. from causes and on the date stated above.			
22a. SIGNATURE Frank N. Ooden		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FRANK N. OODEN, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-11-67	23c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL
24. FUNERAL DIRECTOR ECOL-Schwsb Funeral Home		24b. ADDRESS 15 Louis St. Millie 2101 Studwick Ave.	25a. REC'D BY REGISTRAR MAY 9 1967
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36227

CERTIFICATE OF DEATH

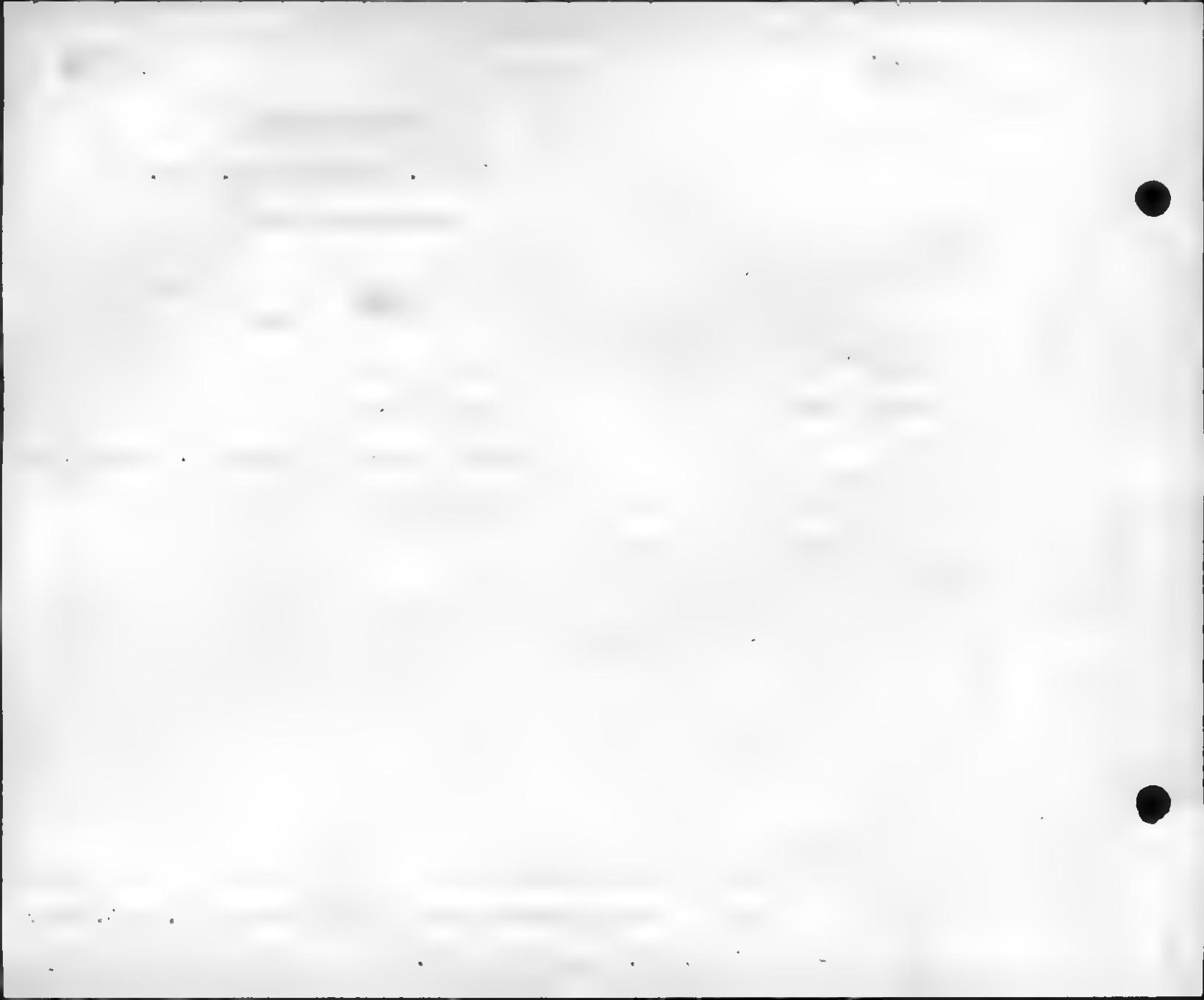
05218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and the event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Pennsylvan</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN lb <u>1 day</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <u>Louise</u>	Middle <u>C.</u>	4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes</u>		
13. FATHER'S NAME <u>Charles Zentz</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Bankard</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Loring Byers-8728 Liberty Rd. Randallstown</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <u>ASHD</u> DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute abdomen</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Baltimore</u> (County) <u>Maryland</u> (State) <u>MD</u>
21. I certify that (I) (this hospital) attended the deceased from <u>5-7</u> , 19 <u>67</u> , to <u>5-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-8-1967</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.				
22a. SIGNATURE <u>Manarkil</u>		22b. DATE SIGNED <u>5-8-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>RUPERTO MANARKIL</u>		22d. ADDRESS <u>BCSH</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/15/67</u>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Druid Ridge Cemetery</u>	
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>		25a. LOCATION (City or Town) <u>Office-505 Cathedral St. Balt. 21201</u>	25b. (County) <u>Maryland</u> (State) <u>MD</u>	
		25c. REC'D. BY REGISTRAR <u>MAY 15 1967</u>	25d. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



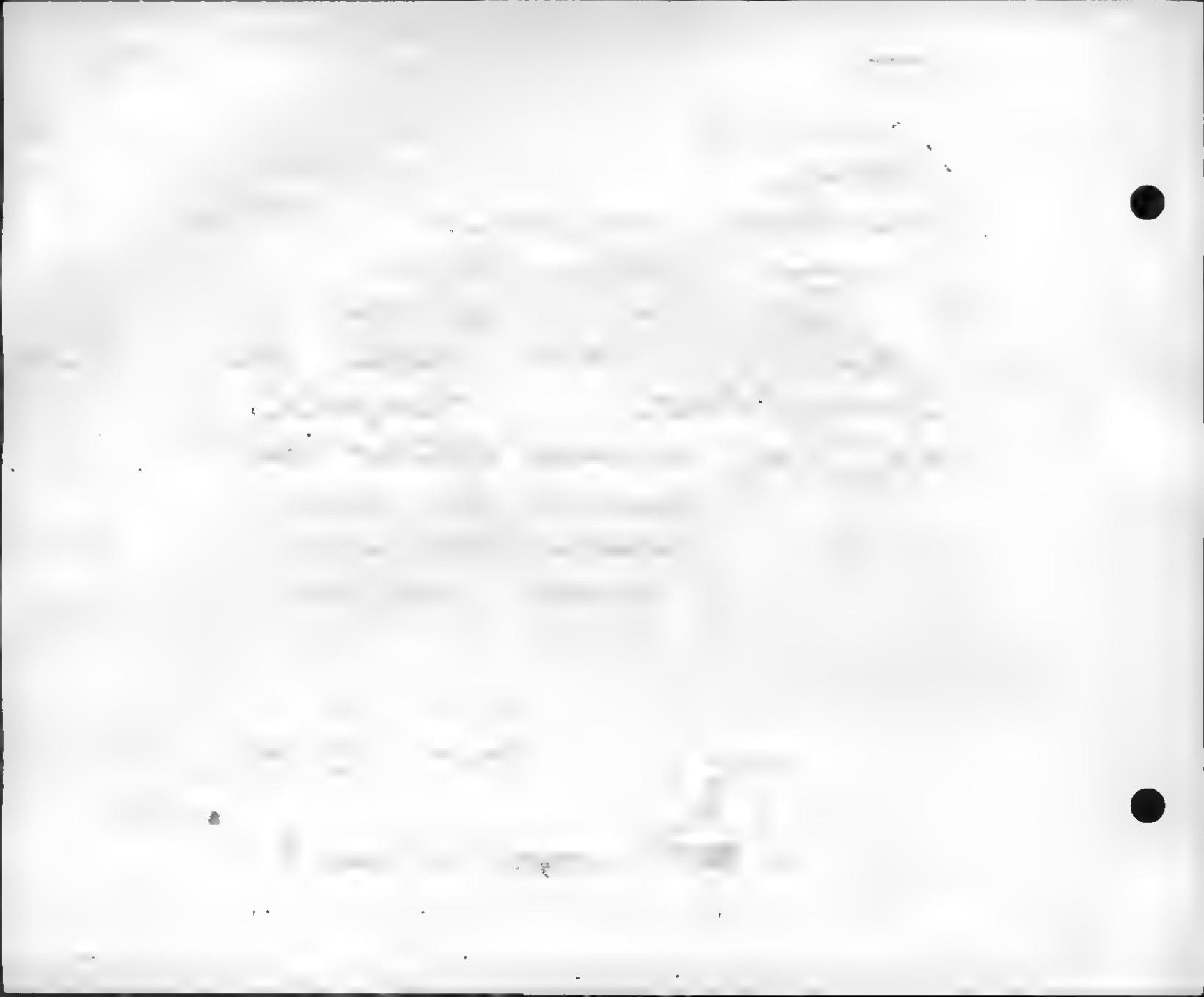
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
<i>Baltimore</i>		a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN lb <i>6 days</i>	
		d CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>574 E. 39th St.</i>	
e NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Greater Baltimore Medical Center</i>		d STREET ADDRESS <i>574 E. 39th St.</i>	
3 NAME OF DECEASED (Type or print)		4 DATE OF DEATH Month Day Year	
First <i>Aurie</i> Middle <i>Catherine</i> Last <i>Byrd</i>		5 8 1967	
S SEX <i>F</i>	6. COLOR OR RACE <i>Caucasian</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>10/9/94</i>
9 AGE (In years lost birthday) <i>82 yrs</i>		10 IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>NA Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NA</i>	
11 BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12 CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13 FATHER'S NAME <i>George C. Parker</i>		14 MOTHER'S MAIDEN NAME <i>Norfolk, Ella</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NA</i>		16 SOCIAL SECURITY NO <i>218-54-2467</i>	
17. INFORMANT <i>Mrs. Alarmed Rithmiller</i>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congestive Heart Failure</i> DUE TO (c) <i>Cardiac arrhythmia</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>46 days</i>	
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) <i>Baltimore</i> (County) <i>Md.</i> (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 2, 1967</i> , to <i>May 8, 1967</i> , that (II) (we) last saw the deceased alive on <i>May 8, 1967</i> , and that death occurred at <i>11:15 A.M.</i> from causes and on the date stated above.			
22a SIGNATURE <i>Sachinna M. Oteyza</i>		22b DATE SIGNED <i>5/8/67</i>	
22c PHYSICIAN'S NAME (Type) <i>Dr. L. M. OTEYZA</i>		22d ADDRESS <i>GBMC Charles St. Md.</i>	
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>May 11, 1967</i>	
23c NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cem.</i>		23d LOCATION (City or Town) <i>Baltimore, Md.</i> (County) <i>Md.</i> (State)	
24 FUNERAL DIRECTOR ADDRESS <i>Mitchell-Wiedefeld Home 6500 York Rd.</i>		25a REC'D BY REGISTRAR DATE <i>MAY 9 1967</i>	
		25b REGISTRAR'S SIGNATURE <i>Charles J. Jagger</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06223

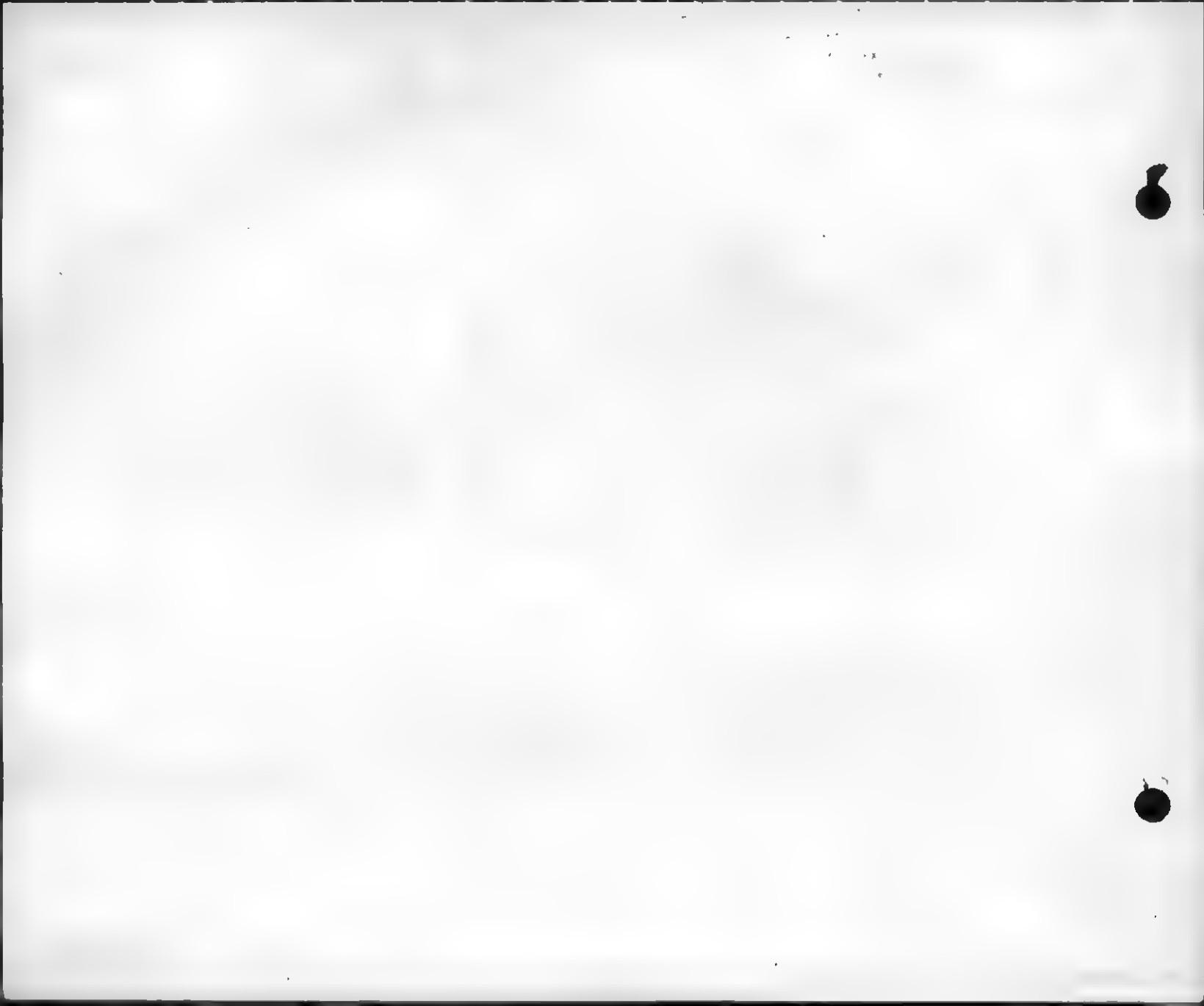
CERTIFICATE OF DEATH

65228

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, ~~and~~ any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN b ESSEX				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 908 C ASHBRIDGE DR		e. STREET ADDRESS 908 C ASHBRIDGE DR				
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED (Type or print)	First THELMA	Middle BYRNE	4 DATE OF DEATH Month MAY Day 8 Year 1967			
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	8 DATE OF BIRTH JUNE 8 1909			
9 AGE (In years last birthday) 57 yrs	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier	10b KIND OF BUSINESS OR INDUSTRY Food store	11 BIRTHPLACE (County & State, or foreign country) VA.			
12 CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME LEO A. CLANKENSHIP		14. MOTHER'S MAIDEN NAME JOSEPHINE LOTH				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16 SOCIAL SECURITY NO	17 INFORMANT PAUL BYRNE	Address ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Anemia from pulmonary infection						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 8 1967		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f (City or town) BALTIMORE	(County) MARYLAND	(State) MD
21. I certify that (I) (this hospital) attended the deceased from 5-8-1967 to 5-8-1967 , that (I) (we) last saw the deceased alive on 5-8-1967 , and that death occurred at 3A M. from causes and on the date stated above						
22a. SIGNATURE Theula Byrne		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Theula Byrne		22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 11, 1967	23c. NAME OF CEMETERY OR CREMATORIAL HOLLY HILLS	23d. LOCATION (City or Town) BALTIMORE	(County) MARYLAND	(State) MD	
24. FUNERAL DIRECTOR JG CONNELLY & SONS		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 12 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1

06230

CERTIFICATE OF DEATH

JC221

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			b. COUNTY <u>Baltimore</u>		
c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2221 Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>			d. STREET ADDRESS <u>2221 Elsinore Ave</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <u>A. Brown</u>	Middle <u>Caldwell</u>	Last	4 DATE OF DEATH	Month <u>May</u> Day <u>14</u> Year <u>1967</u>
S. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>7-2-90</u>	9. AGE (In years last birthday) <u>76 yrs</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Pa.</u>	
13. FATHER'S NAME <u>John E. Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>ANNA Brown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> UNK		16. SOCIAL SECURITY NO. <u>212-17-3768</u>		17. INFORMANT <u>MARGARET WYSONG</u> Address <u>Chase - 1902 Princeton Place Rockville Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Cardio - Resp. Failure</u> <u>Sarcoma of bladder</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that <u>I</u> (this hospital) attended the deceased from <u>May 14, 1967</u> , to <u>May 14, 1967</u> , that <u>I</u> (we) last saw the deceased alive on <u>12-05 AM 19</u> , and that death occurred at <u>1205A</u> , from causes and on the date stated above					
22a. SIGNATURE <u>Denis Chan</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>May 14, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN</u>		22d. ADDRESS <u>9 Bmc</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-18-67</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) <u>Baltimore, Md</u>	(County) (State)	
24. FUNERAL DIRECTOR <u>Ellsworth Armacost - 400 Liberty Heights Ave</u>	ADDRESS <u>ELLSWORTH ARMACOST - 400 LIBERTY HEIGHTS AVE</u>	25a. RECEIVED BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	DATE <u>17 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

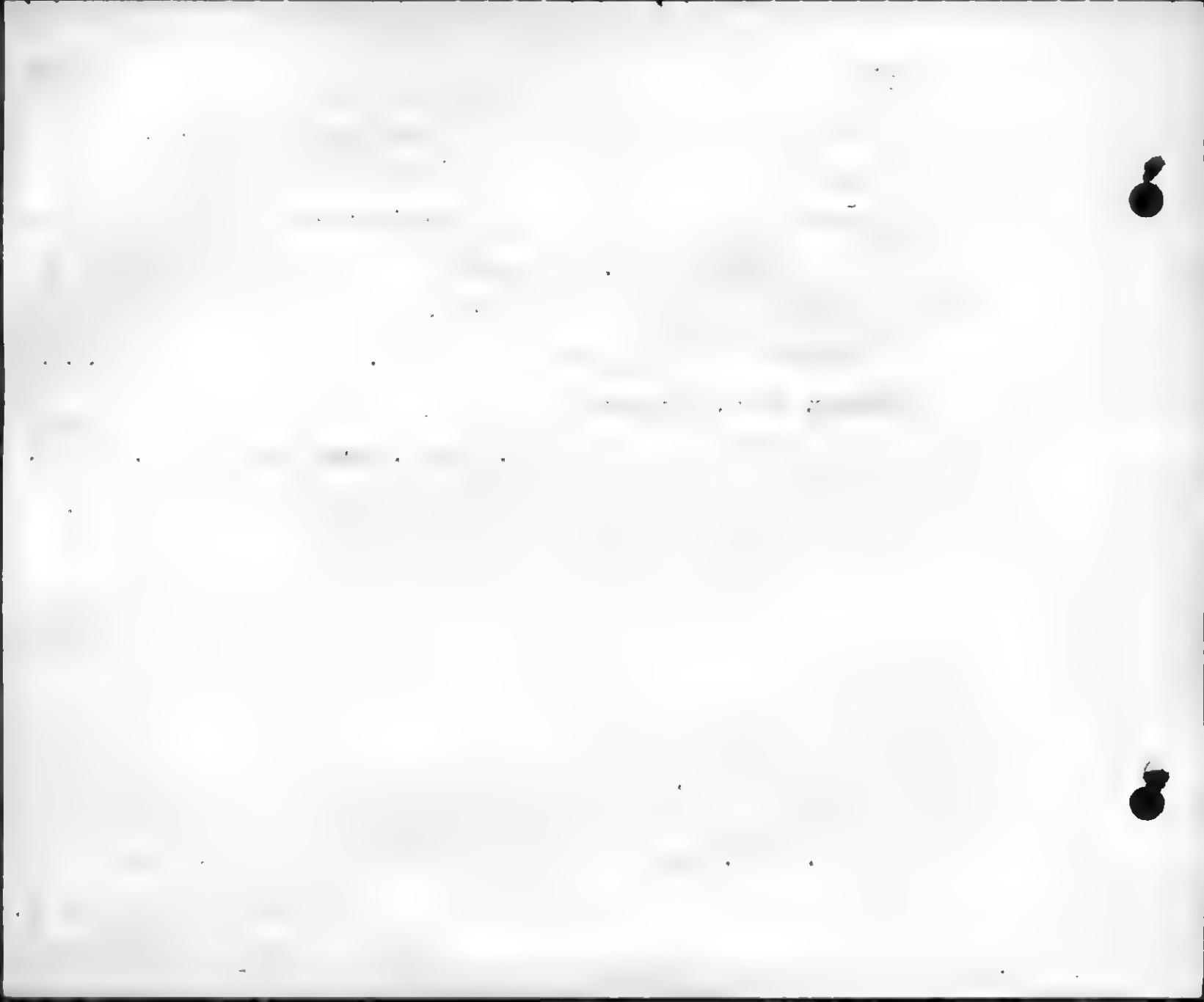
36231

CERTIFICATE OF DEATH

36222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) d. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville			c. LENGTH OF STAY IN 1b e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7416 Monita Road			d. STREET ADDRESS 7416 Monita Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Bertha	Middle M.	Last Carey	4. DATE OF DEATH May 7 1967	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Feb 7, 1889	9. AGE (In years at birthday) 78 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State or foreign country) Baltimore, Md	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Alexander Welle			14. MOTHER'S MAIDEN NAME (unknown) Strauss		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-36-37617		17. INFORMANT Mr. Jerry P. Carey 7416 Monita Rd. Md.	Address Pikesville Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of Kidney, left <i>1967</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), due to (c) <i>(b)</i> <i>(c)</i>					
19. INTERVAL BETWEEN ONSET AND DEATH 6 yrs.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1 Mallow Hill Rd. Baltimore 29, Md.	(County) (State)
21. I certify that (I) physician attended the deceased from May 1, 1967 to May 11, 1967 , that (I) last saw the deceased alive on May 1, 1967 , and that death occurred at 4:45PM , from causes and on the date stated above.					
22a. SIGNATURE 		22b. DATE SIGNED 5/8/67			
22c. PHYSICIAN'S NAME (Type) Dr. Lee J. Gaver		22d. ADDRESS 1 Mallow Hill Rd. Baltimore 29, Md.			
23a. BURIAL, CREMATION, REBURY (Select) Burial		23b. DATE THEREOF 5/10/67	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park	23d. LOCATION (City or Town) 3801 Frederick Rd. Baltimore 29, Md.	
24. FUNERAL DIRECTOR Visoring Byers 8728 Liberty Rd. Dundalk, Md.		ADDRESS 1000 Dundalk Avenue		25a. REC'D BY REGISTRAR MAY 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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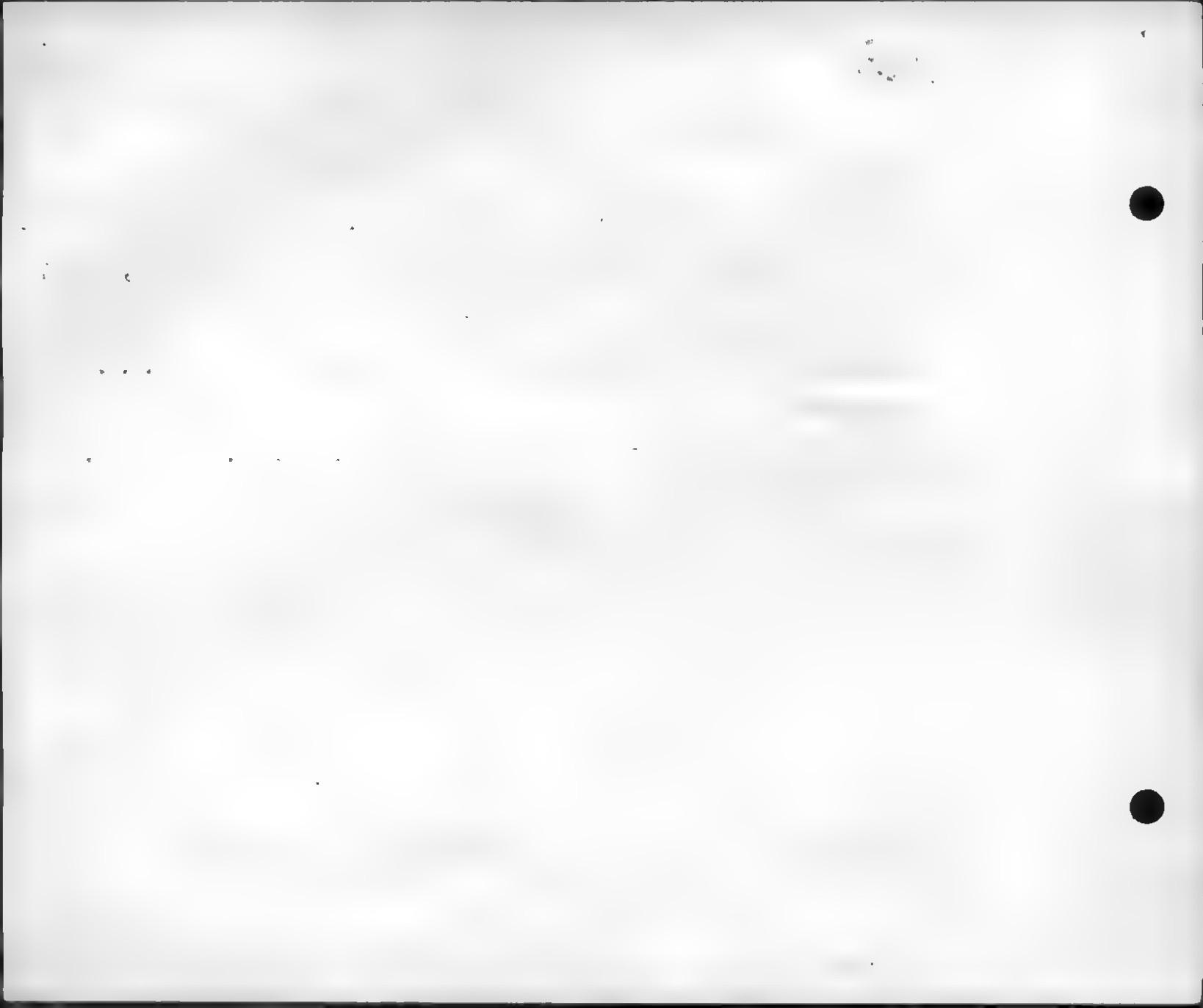
CERTIFICATE OF DEATH

06223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 16 DAYS		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			e. STREET ADDRESS 11 BRISTOL AVENUE		
3. NAME OF DECEASED (Type or print) STANLEY NMI CARSON		4. DATE OF DEATH MAY 6, 1967		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/18/09	9. AGE (In years past birthday) yrs 58
10a. USUAL OCC. PAT ON (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (County & State or foreign country) CANADA	
13. FATHER'S NAME ALBERT CARSON			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES KOREAN		16. SOCIAL SECURITY NO 212 12 22 92		17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.1 DUE TO CARDIO-RESPIRATORY FAILURE INTERVAL BETWEEN ONSET AND DEATH 48 Hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LIVER FAILURE 1 Week DUE TO (c) PARALYTIC ILEUS 1 Week					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Maryland (State)
21. I certify that (X) (this hospital) attended the deceased from April 20, 1967 , to May 6, 1967 , that (X) (we) last saw the deceased alive on May 6, 1967 , and that death occurred at 8 P.M. , from causes and on the date stated above.					
22a. SIGNATURE <i>Milton Ginsberg</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/8/67		
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF MAY 10, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR George J. Gonce Funeral Home		ADDRESS 4001 Gov. Ritchie Highway Balti	25a. REC'D BY REGISTRAR J. Gonce Judge	25b. REC'D BY CLERK'S SIGNATURE MAY 11 1967	

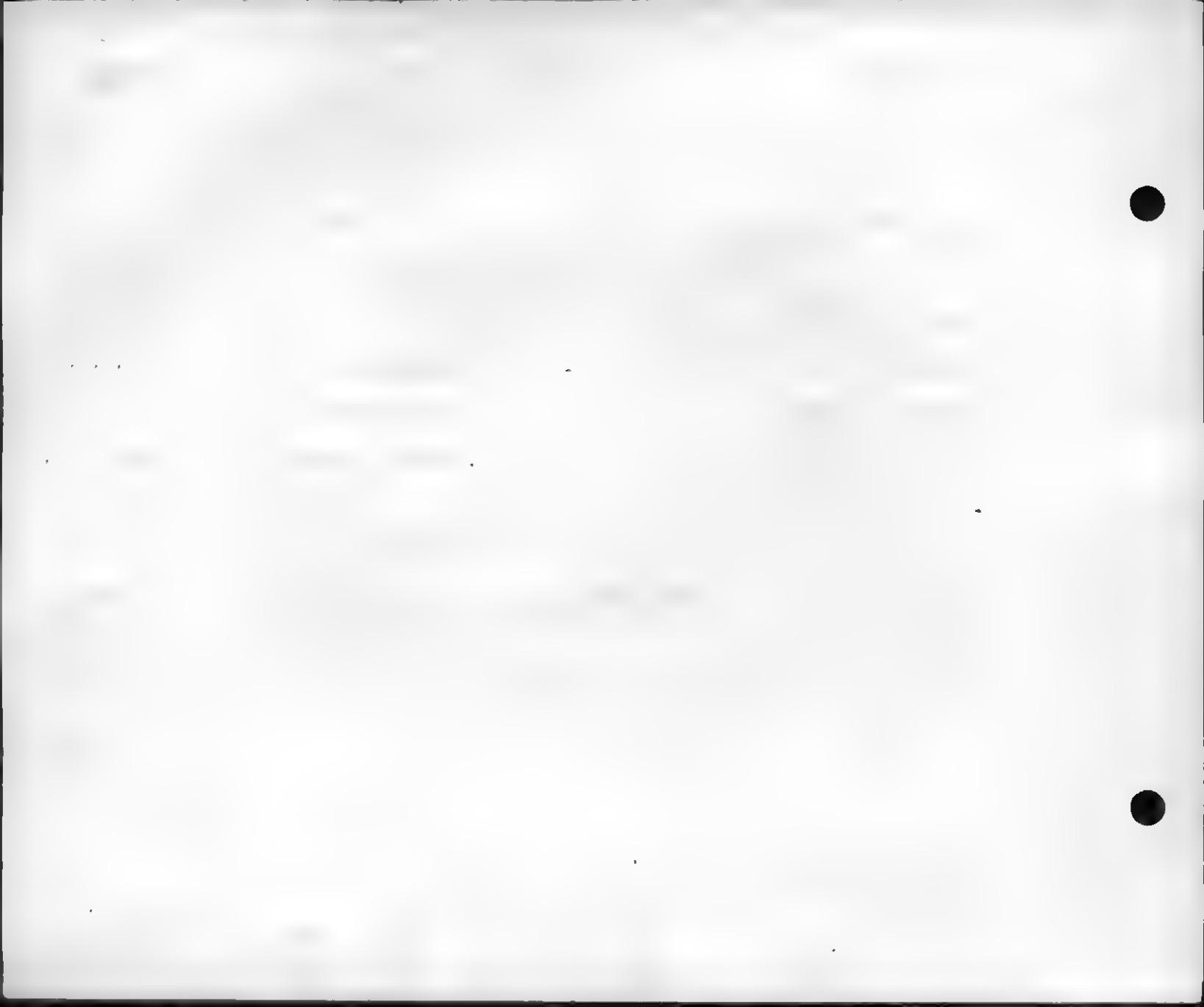


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE MARYLAND b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN TB 14 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			d. STREET ADDRESS 3200 OLD NORTH POINT ROAD		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ANTHONY	Middle STEVEN	Last CATRAMADOS	4. DATE OF DEATH Month MAY Day 1 Year 1967	Month MAY	Day 1	Year 1967	IF UNDER 1 YEAR Months 38 Days Yrs	IF UNDER 24 HRS Hours Min	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/29	9. AGE (In years last birthday) 38 yrs						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER			10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP			11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME STRATIS CATRAMADOS						14. MOTHER'S MAIDEN NAME EUGENIE CALAVETINOS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			16. SOCIAL SECURITY NO. 217 22 91 89			17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			Address		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST						INTERVAL BETWEEN ONSET AND DEATH MINUTES					
Cond. tans, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ARTERIOSCLEROTIC HEART DISEASE (c) BRONCHIOGENIC CYST						UNKNOWN					
						UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJRY (Home, farm factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (s) (this hospital) attended the deceased from 4/17/67 , 19, to 5/1/67 , 19, that (s) (we) last saw the deceased alive on 5/1/67 , 19, and that death occurred at 2:45 P.M. , from causes and on the date stated above.											
22a. SIGNATURE <i>Peter Juvan</i>						22b. DATE SIGNED 5/2/67					
22c. PHYSICIAN'S NAME (Type) PETER J. JUVAN, M. D.						22d. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATON, REMOVAL (From) BUREAU		23b. DATE THEREOF 5/4/67		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NAT. CEMETERY		23d. LOCAT ON (City or Town) (County) (State) BALTIMORE, MD.					
24. FUNERAL DIRECTOR Joris S. Prause		ADDRESS KRAUSE FUNERAL HOME 1216 S. CHARLES ST.		REG'D BY REG'D BY MAY 4 1967		REG'D BY Joris S. Prause					



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06234

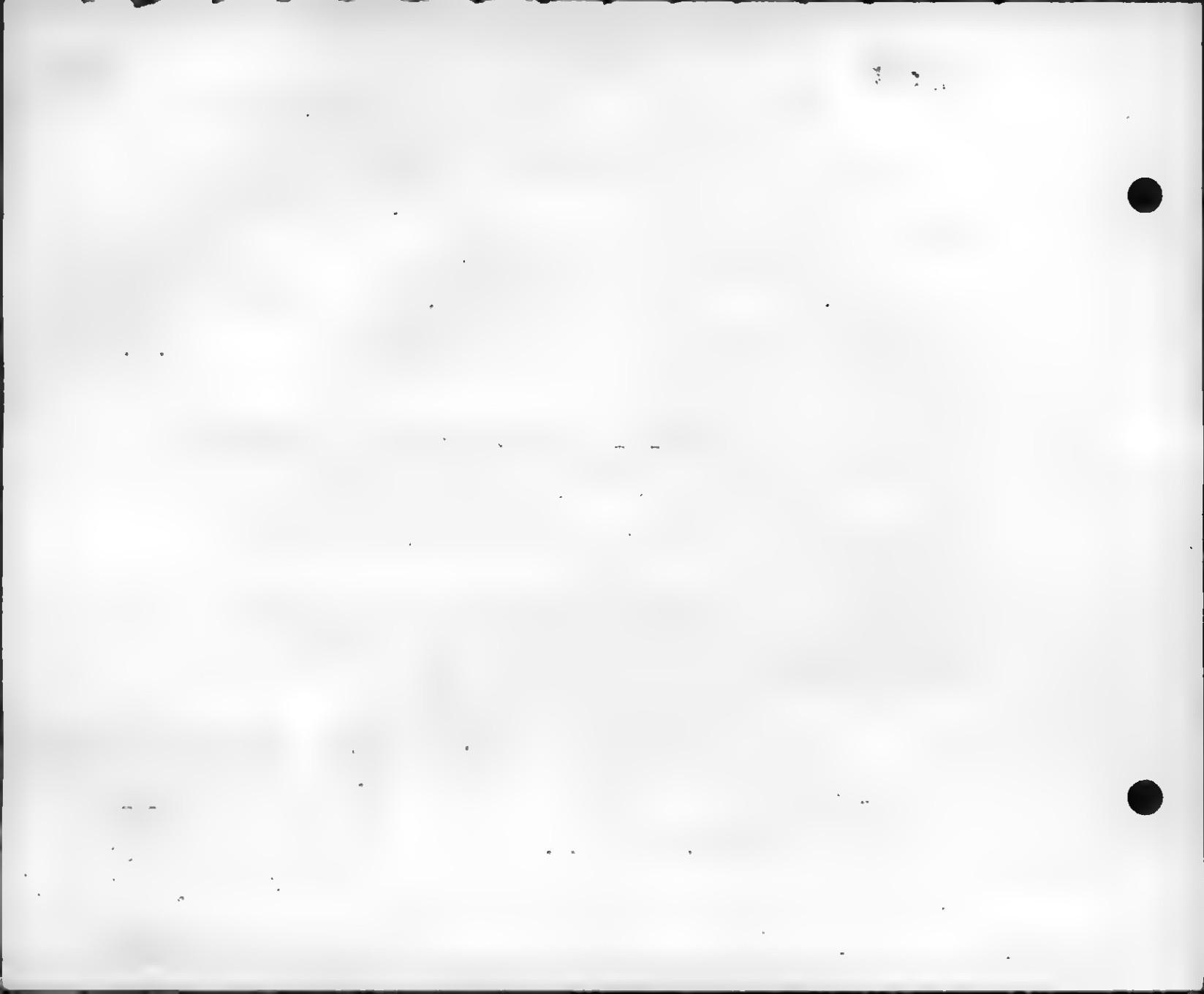
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16225

1. PLACE OF DEATH a. COUNTY Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 22yr 4mth 21dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL	d. STREET ADDRESS 1101 S. Mason Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Margaret	First Margaret	Middle Christner	4. DATE OF DEATH May 9 1967	Month May	Day 9	Year 1967		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1883	9. AGE (in years) IF UNDER 1 YEAR last birthday 83 yrs.	Months Months	Days Days	Hours Hours	Min. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S.					
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO. 219-54-3068J1	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	Myocardial infarction							
DUE TO (b) Arteriosclerotic cardiovascular disease								
DUE TO (c) Generalized arteriosclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Duodenal ulcer with bleeding								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 18 1966 to May 9 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 9 1967 , and that death occurred at 12:05 M, from the causes and on the date stated above.							a. 22d. DATE SIGNED 5-9-67	
22a. SIGNATURE 							M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	22d. ADDRESS SPRING GROVE STATE HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 11 1967	23b. DATE THEREOF New Cemetery	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City, town or county) Old Friends' Road Bellair	(State)				
24. FUNERAL DIRECTOR Krause Funeral Home	ADDRESS 1216 S Charles St	25a. REC'D BY REGISTRAR MAY 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge					



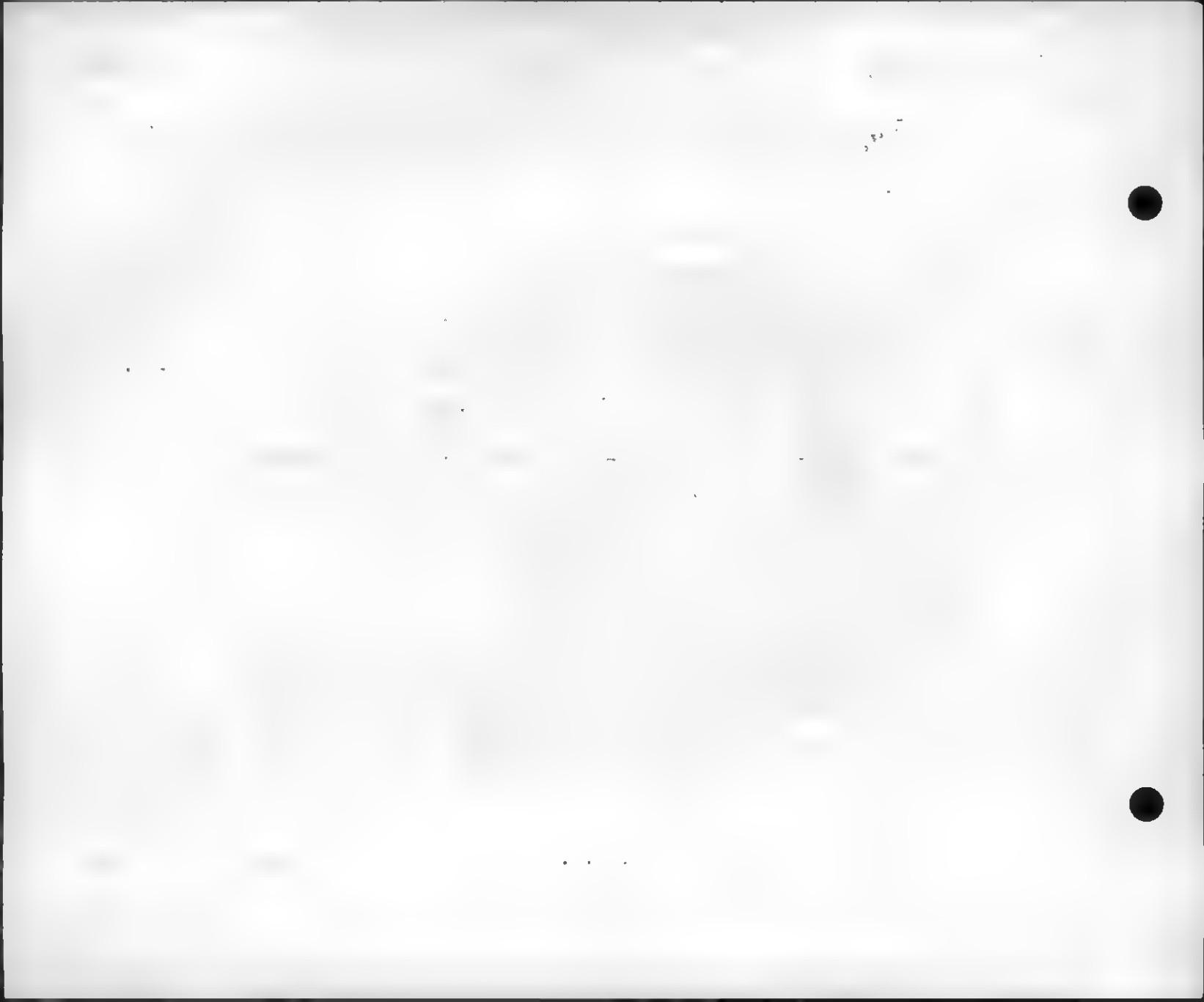
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
96235

CERTIFICATE OF DEATH

1
96226

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b 3mth20dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 216 East Cross Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Gordon	Middle Oscar	Last Cole	4. DATE OF DEATH May 14 1967	Month	Day	Year
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1902		9. AGE (In years last birthday) yrs 64	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Oscar Cole				14. MOTHER'S MAIDEN NAME Jenny Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Army		16. SOCIAL SECURITY NO. 1918-19		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lungs				INTERVAL BETWEEN ONSET AND DEATH			
X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 24, 1967 to May 14, 1967 , that (I) (we) last saw the deceased alive on May 14, 1967 , and that death occurred at p. M, from causes and on the date stated above.							
22a. SIGNATURE Stella Wachsler				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-15-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/67		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc., 1501 East Fort Avenue		25a. RECEIVED BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 25M 1/67							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06236

CERTIFICATE OF DEATH

06227

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <i>Towson</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>601 Sussex Road</i>			d. STREET ADDRESS <i>601 Sussex Road</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Isabelle</i>	Middle <i>V.</i>	Last <i>Conway</i>	4. DATE OF DEATH	Month <i>May</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <i>9-14-1884</i>	9. AGE (in years last birthday) <i>82</i>	F. UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	I. UNDER 24 HRS Days <i>0</i>
13. FATHER'S NAME <i>Thompson</i>			14. MOTHER'S MAIDEN NAME <i>not known</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO <i>214323111A</i>	17. INFORMANT <i>Thomas O. Carroll</i>	Address <i>same</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4201</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>(b)</i> stating the underlying cause <i>(c)</i>			DUE TO <i>Arteriosclerotic Cardio Vascula Disease</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>5217 Havford Road Baltimore Md</i>	(County) (State) <i>21214</i>
21. I certify that (I) (this hospital) attended the deceased from <i>19 May 1967</i> to <i>19 May 1967</i> , that (I) (we) last saw the deceased alive on <i>17 May 1967</i> , and that death occurred at <i>5:30 AM</i> , from causes and on the date stated above					
22a. SIGNATURE <i>Thomas J. Brennan</i>		22b. DATE SIGNED <i>29 May 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>Thomas J. Brennan, M.D.</i>		22d. ADDRESS <i>5217 Havford Road Baltimore Md 21214</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>6-1-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>St. Peter & Paul Cem Cumberland, Md.</i>	23d. LOCATION (City or Town) (County) (State) <i>Cumberland, Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>		25a. REC'D BY REGISTRAR <i>CHARLES JUDGE</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Item 3 Film G 388 5/10

CERTIFICATE OF DEATH

06228

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN MD <i>1 year</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Saints Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gloyd</i>		First <i>b</i>	Middle <i>t.</i>
Last <i>Cook</i>		4. DATE OF DEATH Month <i>May</i> Day <i>5</i> , Year <i>1967</i>	Year
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>6-14-40</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beach</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Con Elec</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Boyle</i>	
13. FATHER'S NAME <i>Loodee</i>		14. MOTHER'S MAIDEN NAME <i>Frances</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>78</i>	
17. INFORMANT <i>Famly - Son</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Arteritis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Lung Tum (Metastasis)</i> DUE TO (c) <i>Bladder Malignancy</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>3 mo</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) <i>Edmondson</i> (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>3/1/1967</i> to <i>3/5/1967</i> that (I) (we) last saw the deceased alive on <i>3/1/1967</i> , and that death occurred at <i>12:30</i> M, from the causes and on the date stated above		22b. DATE SIGNED <i>5/15/67</i>	
22a. SIGNATURE <i>Wm. Cook Jr.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>CLIFFIE RATLIFF, JR.</i>		22d. ADDRESS <i>4605 Edmondson Ave #22</i>	
23a. BURIAL OR CREMATION, REMOVAL (Specify) <i>5/8/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Paul's</i>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook Jr.</i>		ADDRESS <i>Valleyview Lane</i>	25a. REC'D BY REGISTRAR DATE <i>Charles Judge</i> MAY 8 1967
			25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

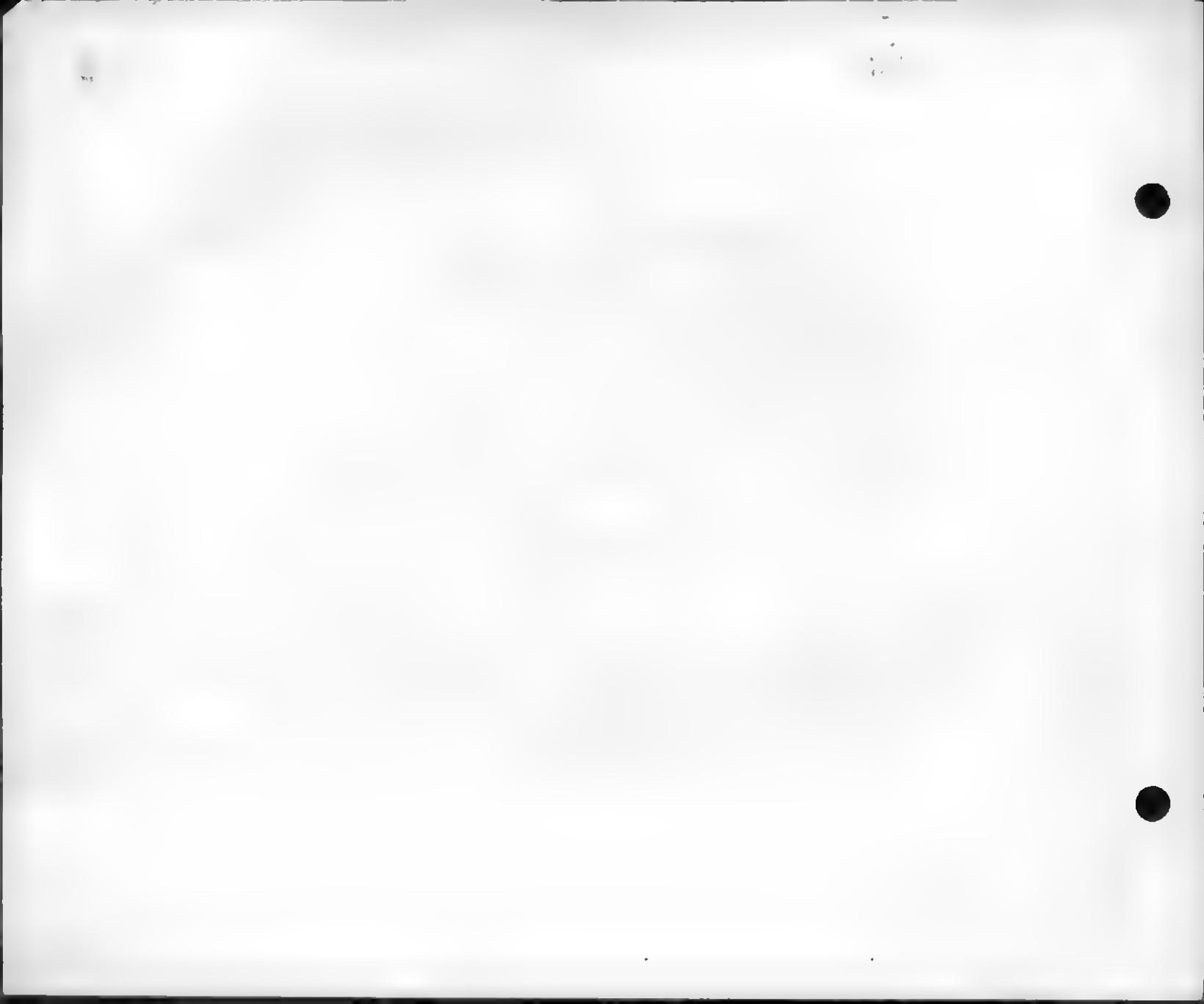
MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96238

CERTIFICATE OF DEATH

DCD29

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>			MARYLAND			2. USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) a. STATE <i>Md</i>			b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calverville</i>			c. LENGTH OF STAY IN 1b <i>4 days</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City</i>								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Spring Grove State Hospital</i>						d. STREET ADDRESS <i>321 Oaklee Village - Z-29</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Margaret Ellen Coppinger</i>			Fst	Middle	last	4. DATE OF DEATH Month <i>5</i>			Day <i>1</i>	Year <i>1967</i>				
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-09-02</i>			9. AGE (In years last birthday) <i>64 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>		11. IF UNDER 24 HRS Hours <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State or foreign country) <i>Ireland</i>			12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>					
13. FATHER'S NAME <i>PATRICK [REDACTED] Kerrigan</i>						14. MOTHER'S MAIDEN NAME <i>MARGARET CARTY</i>			Address <i>SAME</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO			17. INFORMANT <i>WILLIAM COPPINGER</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>		
									<i>myocardial infarction</i>			<i>years</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <i>4-28, 1967</i> to <i>5-1, 1967</i> that (I) (we) last saw the deceased alive on <i>5-1, 1967</i> , and that death occurred at <i>10:30 AM</i> , from causes and on the date stated above.														
22a. SIGNATURE <i>Rolando Vieta</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <i>5-1-67</i>					
22c. PHYSICIAN'S NAME (Type) <i>ROLANDO VIETA</i>			22d. ADDRESS <i>Spring Grove State Hospital</i>			23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE THEREOF <i>5-5-1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>	25a. REC'D BY REGISTRAR DATE <i>MAY 3 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Avenue</i>			ADDRESS <i>21229</i>			25c. REC'D BY REGISTRAR DATE <i>MAY 3 1967</i>								
VR A15 (4) 20 M 1/66														



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 113 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1 PLACE OF DEATH a COUNTY Baltimore MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c LENGTH OF STAY IN lb 1 Hour d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d STREET ADDRESS 1616 Dogwood Hill Rd. e S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3 NAME OF DECEASED First Sarah Middle Long Last Cornthwaite <small>(Type or print)</small>						4 DATE OF DEATH May 7, 1967			Month May Day 7 Year 1967					
5 SEX Female		6. COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 9/14/24		9 AGE (in years last birthday) 42 yrs		10 IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guidance counselor				10b. KIND OF BUSINESS OR INDUSTRY School				11 BIRTHPLACE (State or foreign country) Ocala, Fla.				12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13 FATHER'S NAME John Long						14 MOTHER'S MAIDEN NAME Evlyn Moon								
15 WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(Yes, no, or unknown) (If yes give war or dates of service)</small> No						16 SOCIAL SECURITY NO 262-26-3232			17 INFORMANT Mr. David L. Cornthwaite 1616 Dogwood Hill			Address		
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <small>45-11</small> <small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost</small> <small>(b)</small> <small>DUE TO</small> <small>(c)</small>						<small>INTERVAL BETWEEN ONSET AND DEATH</small> <small>3 days</small>								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a EXTERNAL CAUSE WAS <small>PR MARY</small> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)												
20c TIME OF INJURY Month, Day, Year <small>Hour o m</small> <small>p.m.</small> 19		20d INJURY OCCURRED <small>While at work</small> <input type="checkbox"/> <small>Not While at work</small> <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town)		<small>(County)</small>		<small>(State)</small>				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from:														
<small>Natural causes</small> <input checked="" type="checkbox"/> <small>Accident</small> <input type="checkbox"/> <small>Suicide</small> <input type="checkbox"/> <small>Homicide</small> <input type="checkbox"/> <small>Undetermined manner</small> <input type="checkbox"/>														
<small>ACTUAL SIGNATURE</small> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <small>Address (Street, city, town, or county)</small> DATE SIGNED 5/10/67														
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/10/67		23c NAME OF CEMETERY OR CREMATORIUM Friends Burial Grounds Cem.		23d LOCATION (City or Town) Baltimore, Maryland		<small>(County)</small>		<small>(State)</small>				
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		ADDRESS		25a REC'D BY REGISTRAR MAY 10 1967		25b REGISTRAR'S SIGNATURE 								
<small>VR A15ME (5)</small> <small>6M 1/67</small>														



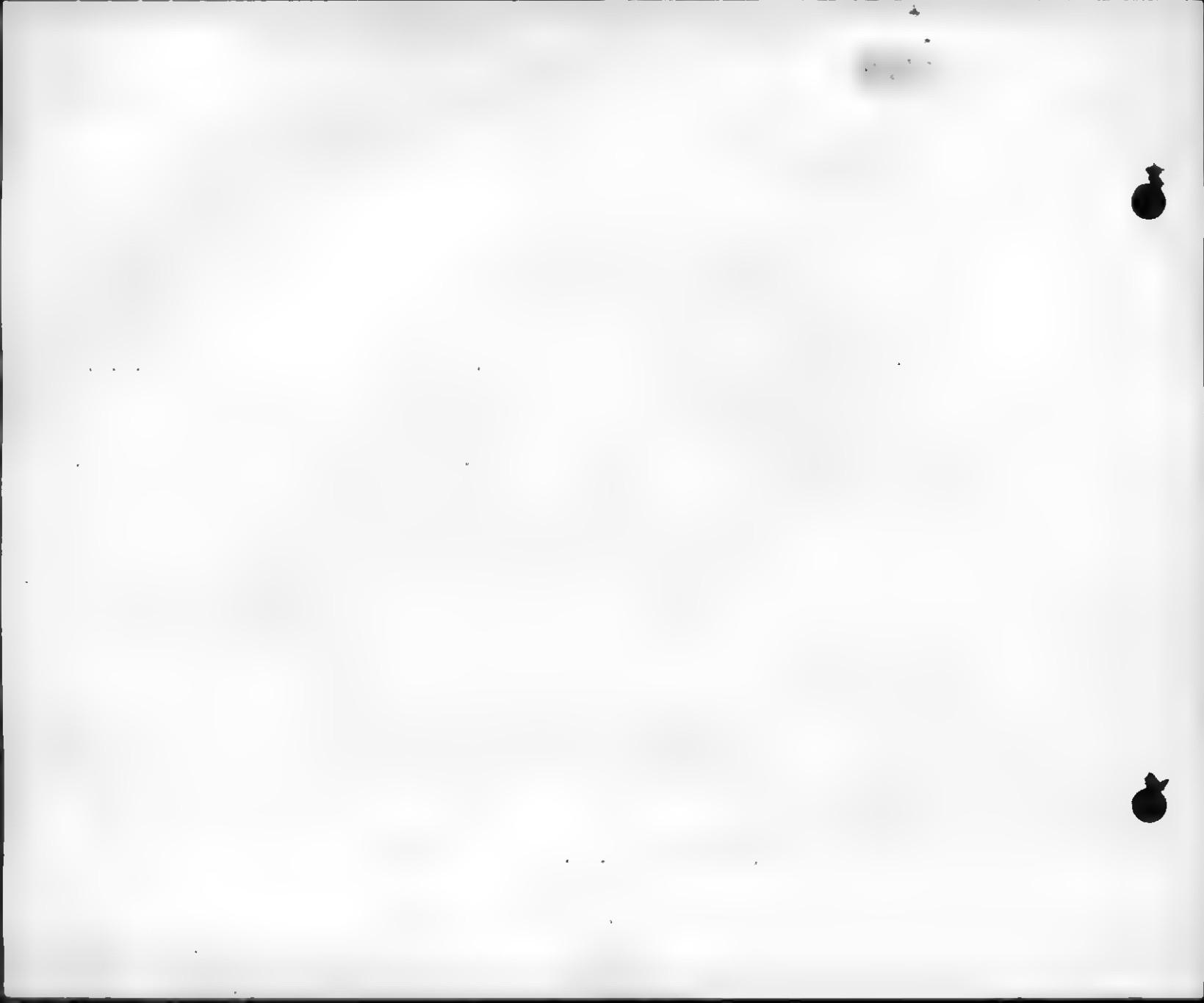
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06240

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN b 19 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS Finksburg	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle HARVEY	Last CRESS
4. DATE OF DEATH	Month MAY	Year 14	Day 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 11/15/86	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	11. IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	10b. KIND OF BUSINESS OR INDUSTRY Congoleum-Nairn Inc.	11. BIRTHPLACE (County & State, or foreign country) Carrollton, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Cress		14. MOTHER'S MAIDEN NAME Mary Lou Dutrow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 216-07-42-25	17. INFORMANT Clin. Rec. VA Hospital, Ft. Howard, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH RECENT	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause PARKINSON DISEASE, OLD		(b) PULMONARY INFARCTION, MULTIPLE, BILATERAL	
		(c) ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE old	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) PARKINSON DISEASE, OLD		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour: o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA HOSPITAL, FORT HOWARD, MARYLAND
20f. (City or town) (County) (State)		22b. DATE SIGNED 5/15/67	
21. I certify that (A) (this hospital) attended the deceased from April 25, 1967 , to May 14, 1967 that (A) (we) last saw the deceased alive on May 14, 1967 , and that death occurred at 1:10 PM from causes and on the date stated above.		22c. PHYSICIAN'S NAME (Type) RAUL F. DeCASTRO, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/67	23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery
24. FUNERAL DIRECTOR J. E. Myers, Jr. Myers Funeral Home		25a. ADDRESS Longwell Avenue	25b. LOCATION (City or Town) Westminster, Carroll, Md.
		25c. REC'D BY REGISTRAR MAY 18 1967	25d. REGISTRAR'S SIGNATURE Charles George



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner Office along with your files.

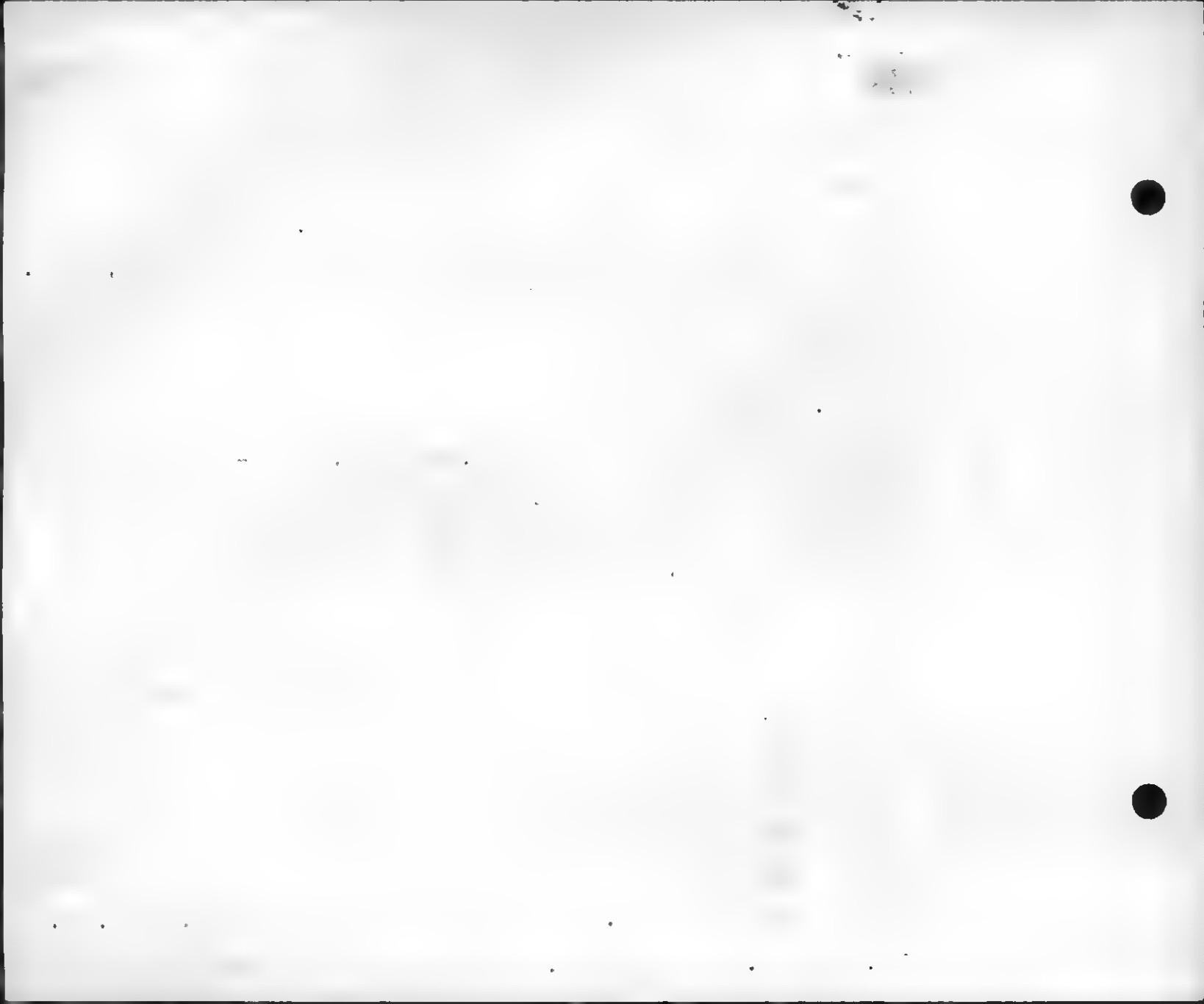
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

36241

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36232

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sweetair		c. LENGTH OF STAY IN b. 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS Baldwin Mill Rd. Box 181		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) REGINA ANN DALTON		First REGINA	Middle ANN	Last DALTON	4. DATE OF DEATH MAY 16, 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/1945		9. AGE (in years last birthday) 22 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William M. Dalton			14. MOTHER'S MAIDEN NAME Gertrude R. Riley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Mr. William M. Dalton - Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMED CAUSE (a) Crushing Injury to skull DUE TO Multiple Fractures INTERVAL BETWEEN ONSET AND DEATH 8234 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Multiple Fractures (c) Fractured Pelvis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRI BE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) Running Auto that ran off Road & struck Edg			
20c. TIME OF INJURY Month Day Year Hour am pm May 16 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office, etc.) Highway Secretary Baldwin St	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.		22. DATE SIGNED 5/16/67			
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Long Green, Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Johns Cemetery	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14		25a. REC'D BY REGISTRAR DATE MAY 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

DC233

06242

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER		e. STREET ADDRESS 713 Carolyn Road				
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED (Type or print)	First AUGUSTA	Middle DANGO	Last			
4 DATE OF DEATH	Month May	Day 17,	Year 1967			
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8 DATE OF BIRTH 6-10-1893	9 AGE (In years last birthday) 73 yrs	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days Hours Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) Russia		12 CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Unknown - Huffins		14 MOTHER'S MAIDEN NAME Helen Kresh				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO 215-01-3179				
17 INFORMANT		Address Mrs. Elsie E. Bensinger, 713 Carolyn Rd.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest secondary to old + DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) probably Acute infarction DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 8 days				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from May 11, 1967 to May 17, 1967, that (I) (we) last saw the deceased alive on May 17, 1967, and that death occurred at 10:45 A.M. from causes and on the date stated above.						
22a SIGNATURE LUDICINA M. OPEYZA		M.D. <input type="checkbox"/> ATTENDING PHYS.	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b DATE SIGNED 5/17/67	
22c PHYSICIAN'S NAME (Type) LUDICINA M. OPEYZA		22d ADDRESS 6701 N. Charles St. MD. 21204				
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 5-20-1967	23c NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	23d LOCATION (City or Town) Baltimore, Maryland		
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		ADDRESS 21229	25a REC'D BY REGISTRAR DA MAY 22 1967	25b REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 25M 1/6						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06243

CERTIFICATE OF DEATH

06234

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD	c. LENGTH OF STAY IN 1b 364 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21229	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 416 N. DENNISON STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) DEWEY J. DANIEL	First DEWEY	Middle J.	Last DANIEL
4 DATE OF DEATH MAY 2 19 67	Month MAY	Day 2	Year 19 67
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/23/98
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER		10b KIND OF BUSINESS OR IND.STRY SHIP BUILDING	9 AGE (In years last birthday) 68 yrs.
13. FATHER'S NAME ELISHA DANIEL		11 BIRTHPLACE (County & State, or foreign country) WELDON, NORTH CAROLINA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 218 01 57 71	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY, IMMED AT CAUSE (a) BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b)		DUE TO	
(c)		DUE TO	
(d)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ENCEPHALOMALACIA AND GENERALIZED ARTERIOSCLEROSIS			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH FORT HOWARD, MARYLAND
20f. (City or town) BALTIMORE (County) MARYLAND (State) MARYLAND			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/3/66 , 19, to 5/2/67 , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/2/67 , 19, and that death occurred at 2:00 PM , from causes and on the date stated above.			
22a. SIGNATURE J. D. Talbert		22b. DATE SIGNED 5/2/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-5-67	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL
24. FUNERAL DIRECTOR		23d. LOCATION (City or Town) BALTIMORE, MARYLAND (County) MARYLAND (State) MARYLAND	
		25a. ADDRESS MORTEN & DYETT FUNERAL HOME	25b. REG'D. BY REGISTRAR CHARLES JUDGE
		25c. DATE 1701 LAURENS ST BALTIMORE MAY 4 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06244

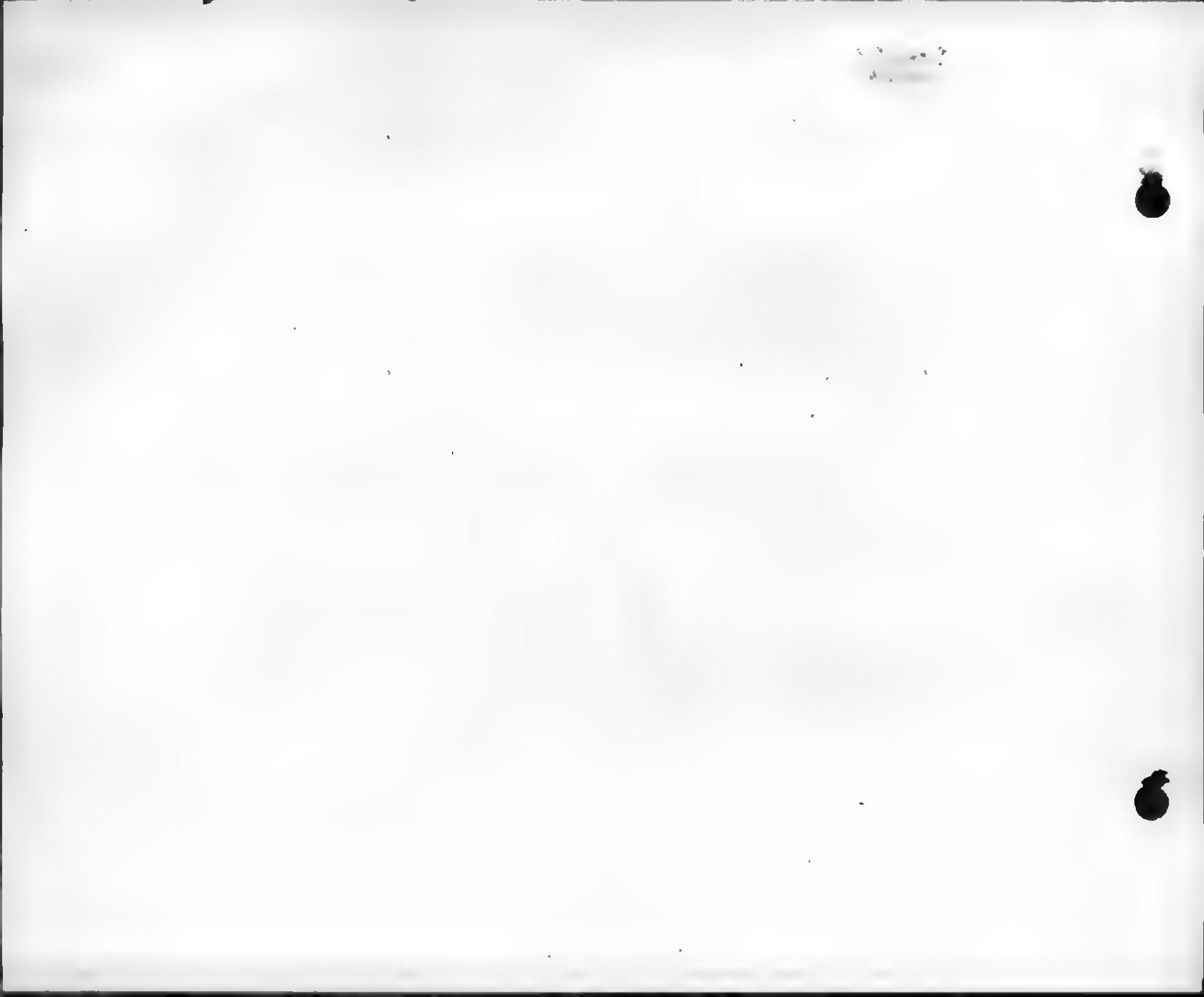
CERTIFICATE OF DEATH

35235

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		e. STREET ADDRESS 205 Patann Road	
3. NAME OF DECEASED (Type or print) ROBERT L. DAVIS		4. DATE OF DEATH Last Month Day Year 1967 May 5 1967	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-29-1893
9 AGE (In years last birthday) 73 yrs		11 BIRTHPLACE (County & State, or foreign country) Penna.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. County Commissioner		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry C. Davis		14. MOTHER'S MAIDEN NAME Catherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 207123654A	
17. INFORMANT Address Mrs. George Bell, 205 Patann Rd, Timonium-21093			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of Colon with metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH Days	
58 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO _____ (c) DUE TO _____ _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from April 27, 1967, to May 5, 1967, that (I) (we) last saw the deceased alive on May 5, 1967, and that death occurred at 9:00 P.M. from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>A. Allan Spier</i>		22b. DATE SIGNED 5/6/67	
22c. PHYSICIAN'S NAME (Type) Dr. A. Allan Spier		22d. ADDRESS 1501 Penbridge Rd, Balto, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF May 6, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Greenmount
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		23e. REC'D BY REGISTRAR	
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.-Baltimore, Md. - 14		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, after death. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item #9 Film #304 6/2/67 10036

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1D 1 mo. 10d.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)	First Rosa	Middle MAISIE	Last DAVIS
4. DATE OF DEATH Month MAY	Month 29	Day 1967	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-70
9. AGE (in years last birthday) 77 yrs.	10. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (County & State, or foreign country) SCOTT CAROLINA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thos. Lewis	14. MOTHER'S MAIDEN NAME Addis	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 219-01-3009		17. INFORMANT CARSON W. CLEGG, JR.	Address 1610 Kyle Court
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] CONGESTIVE HEART FAILURE			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 93X			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PNEUMONIA		(b) DUE TO ETIOLOGY UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) GENERALIZED ARTERIOSCLEROSIS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spring Grove State Hospital
20f. (City or town) Baltimore		(County) (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from APRIL 19, 1967 , to MAY 29, 1967 , that (I) (we) last saw the deceased alive on APRIL 19, 1967 , and that death occurred at 3:59 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Morris Meiller		22b. DATE SIGNED 5/29/67	
22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery
24. FUNERAL DIRECTOR McCally - 237		ADDRESS Patapsco Ave.	25a. REC'D BY REGISTRAR DATE MAY 31 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

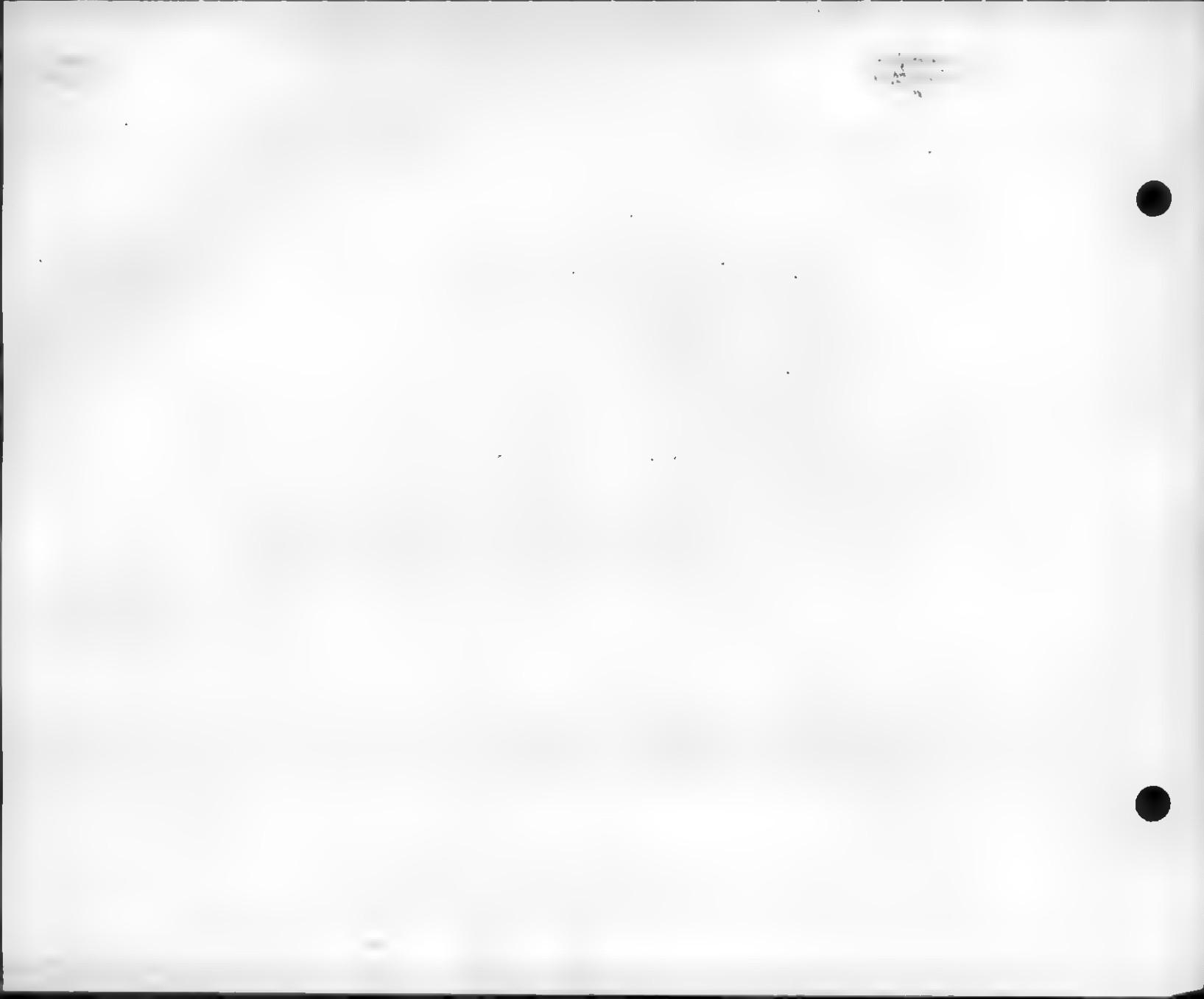
06246

CERTIFICATE OF DEATH

CS237

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b		b. COUNTY WASHINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 119E WASHINGTON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LAWRENCE	Middle BERNARD	Last DEE	4. DATE OF DEATH Month MAY	Year 1967
5. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-15-1906	9. AGE (In years last birthday) 66 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) MASS.	
13. FATHER'S NAME DELLAN DEE		14. MOTHER'S MAIDEN NAME ELLEN FLYNN		12. CITIZEN OF WHAT COUNTRY? USA.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) undescribed		16. SOCIAL SECURITY NO 207-09-1046		17. INFORMANT Address Records, Mount Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Obstructive Airways disease DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH years					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) FAR ADV. PULMONARY TUBERCULOSIS					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, fram causes and on the date stated above					
22a. SIGNATURE Wm. Newcomer.		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 12, 1967	23c. NAME OF CEMETERY OR CREMATORY New Calvary Cemetery Baltimore, Md.		23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Newell Funeral Home, P.O. Box 5-244		ADDRESS Po Box 5-244		25a. REG'D BY REGISTRAR MAY 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/66				DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

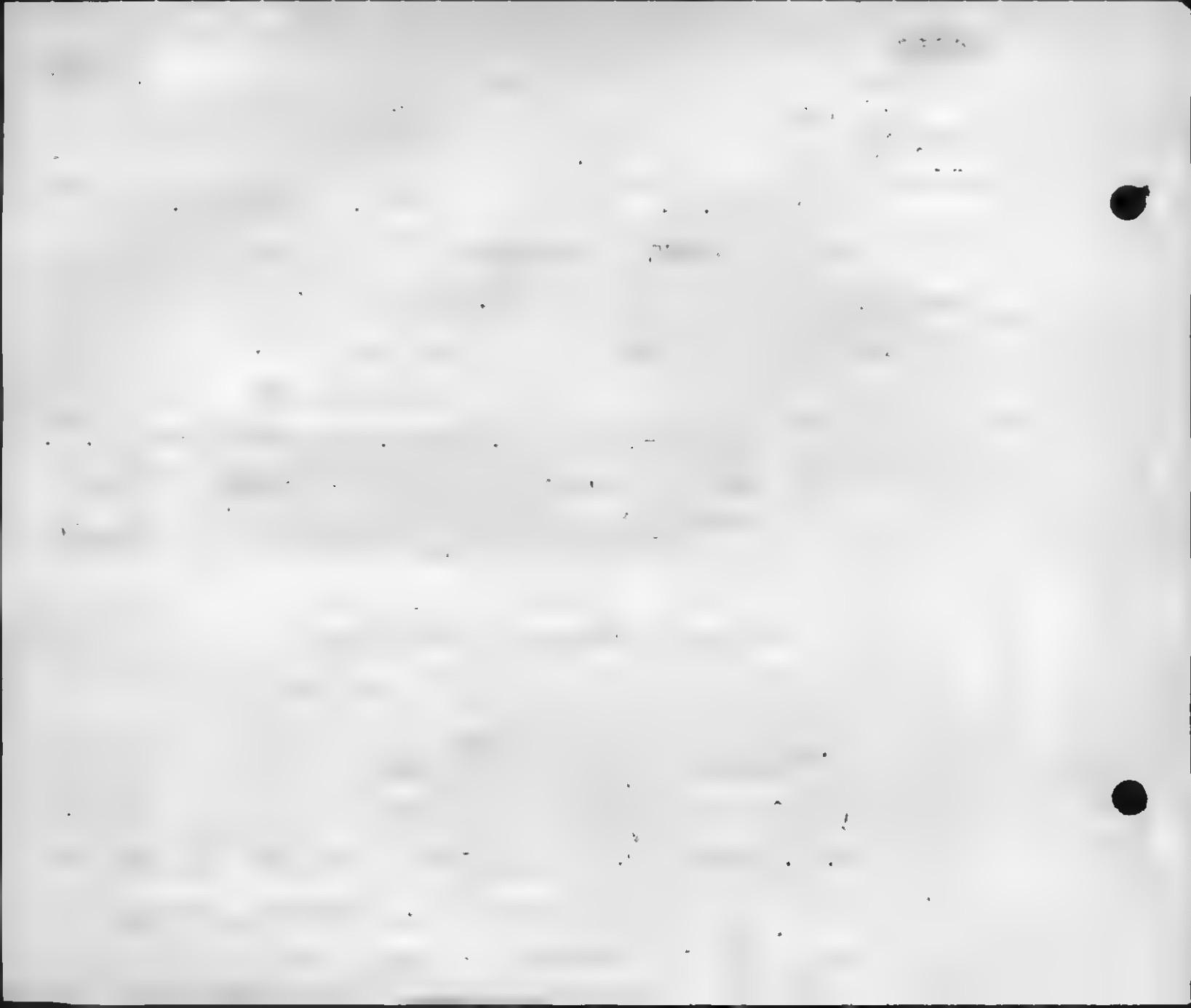
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb 20 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 206 Tyrone Rd. N. 21212		d. STREET ADDRESS 206 N. Tyrone Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JESSIE	Middle LOUISE.	Last DEFIBAUGH
4. DATE OF DEATH Month May	Day 24,	Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Nov. 24, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (County & State or foreign country) Uniontown, Penna.	9. AGE (In years last birthday) IF UNDER 1 YEAR 86 yrs.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Charles Doran	14. MOTHER'S MAIDEN NAME Amanda Cup	Address 21212
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank & dates of service) No		16. SOCIAL SECURITY NO., 17. INFORMANT 214-07-1922D Mrs. Helen D. Krause-206 Tyrone Rd. N.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <i>Mass in abdomen (etiology)</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 weeks.	
20c. TIME OF INJURY Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) <i>(This hospital)</i> attended the deceased from Sept. 1958 to May 1967 , that (I) <i>(I)</i> last saw the deceased alive on 23 May 1967 and that death occurred at N. M. from the causes and on the date stated above.	
22a. SIGNATURE <i>Tom H. Kammer Jr.</i>		22b. DATE SIGNED 5/24/67	
22c. PHYSICIAN'S NAME (Type) Wm. H. Kammer, Jr.		ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 6011 York Rd. Baltimore Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/67	
23c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Burial Pk.		23d. LOCATION (City, town or county) Cumberland Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		25a. REC'D BY REGISTRAR DATE MAY 29 1967	
George Funeral Home - Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Charles J. Geiger	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06248

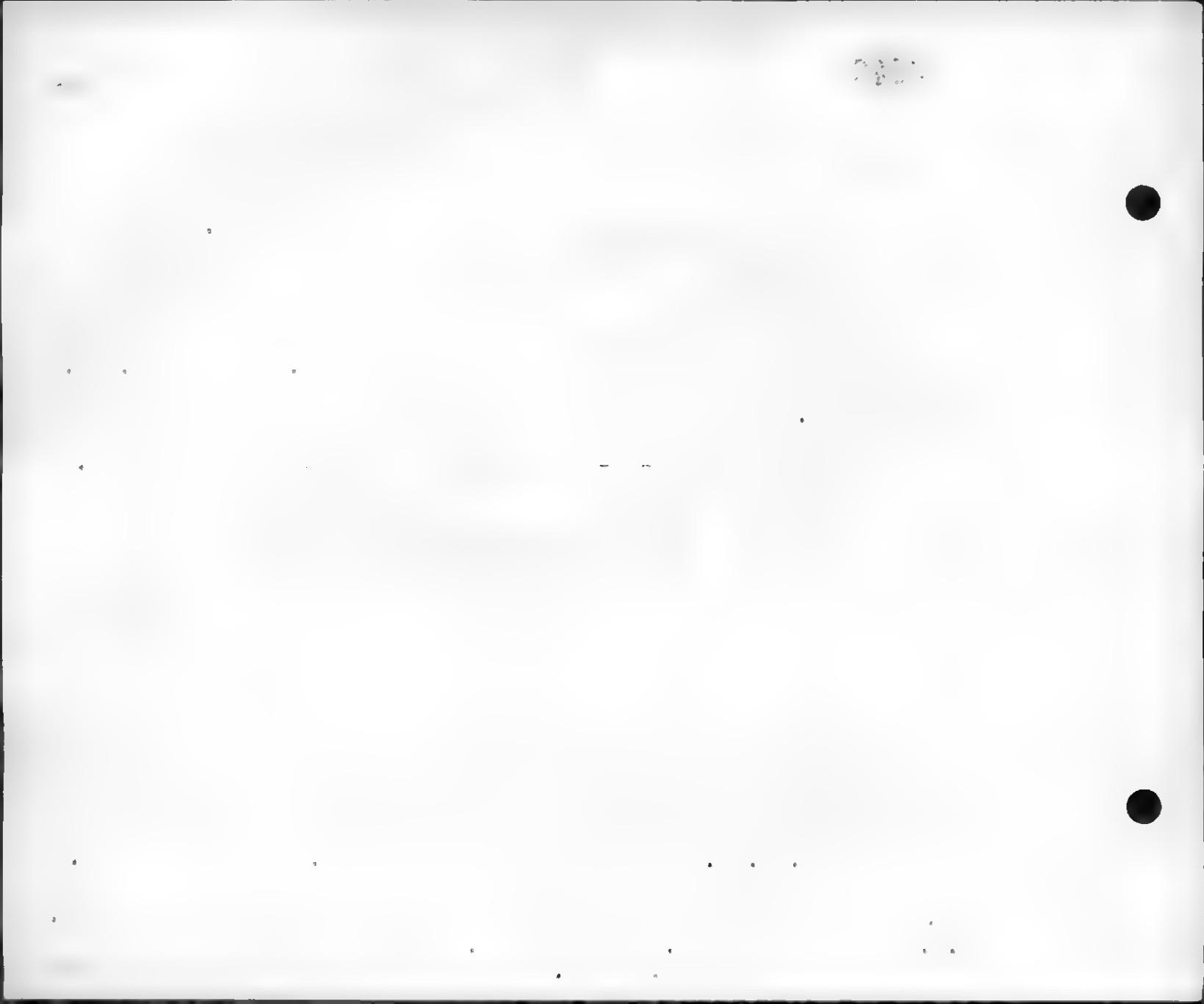
CERTIFICATE OF DEATH

06248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages and M should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home		d. STREET ADDRESS 3401 N. Charles St. 21218	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Boykin Dell		4. DATE OF DEATH May 19 1967	Month Doy Year
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/14/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years lost birthday) 91 yrs
13. FATHER'S NAME William A. Boykin		11. BIRTHPLACE (County & State, or foreign country) Norfolk, Va.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No		14. MOTHER'S MAIDEN NAME Elizabeth Whitehead Irwin	
16. SOCIAL SECURITY NO. 220-54-6188		17. INFORMANT Bernard Boykin, 1919 Ruxton Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Due to (c)		INTERVAL BETWEEN ONSET AND DEATH 29 years 2 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1/57
21. I certify that (I) (this hospital) attended the deceased from 1/57 to 5/19 , 1967, last saw the deceased alive on 3/18/67 , and that death occurred at 453A M, from causes and on the date stated above.		20f. (City or town) 1967	(County) 5/19/67
22a. SIGNATURE M.B. Levin		22b. DATE SIGNED 5/19/67	
22c. PHYSICIAN'S NAME (Type) Dr. M. B. Levin		22d. ADDRESS 218 E. University Pkwy.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial		23b. DATE THEREOF 5/24/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cedar Grove
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		23d. LOCATION (City or Town) Norfolk	(County) Va.
4905 York Rd. Balto. Md.		25a. REC'D BY REGISTRAR MAY 22 1967	25b. REGISTRAR'S SIGNATURE James J. Murphy



MARYLAND STATE DEPARTMENT OF HEALTH

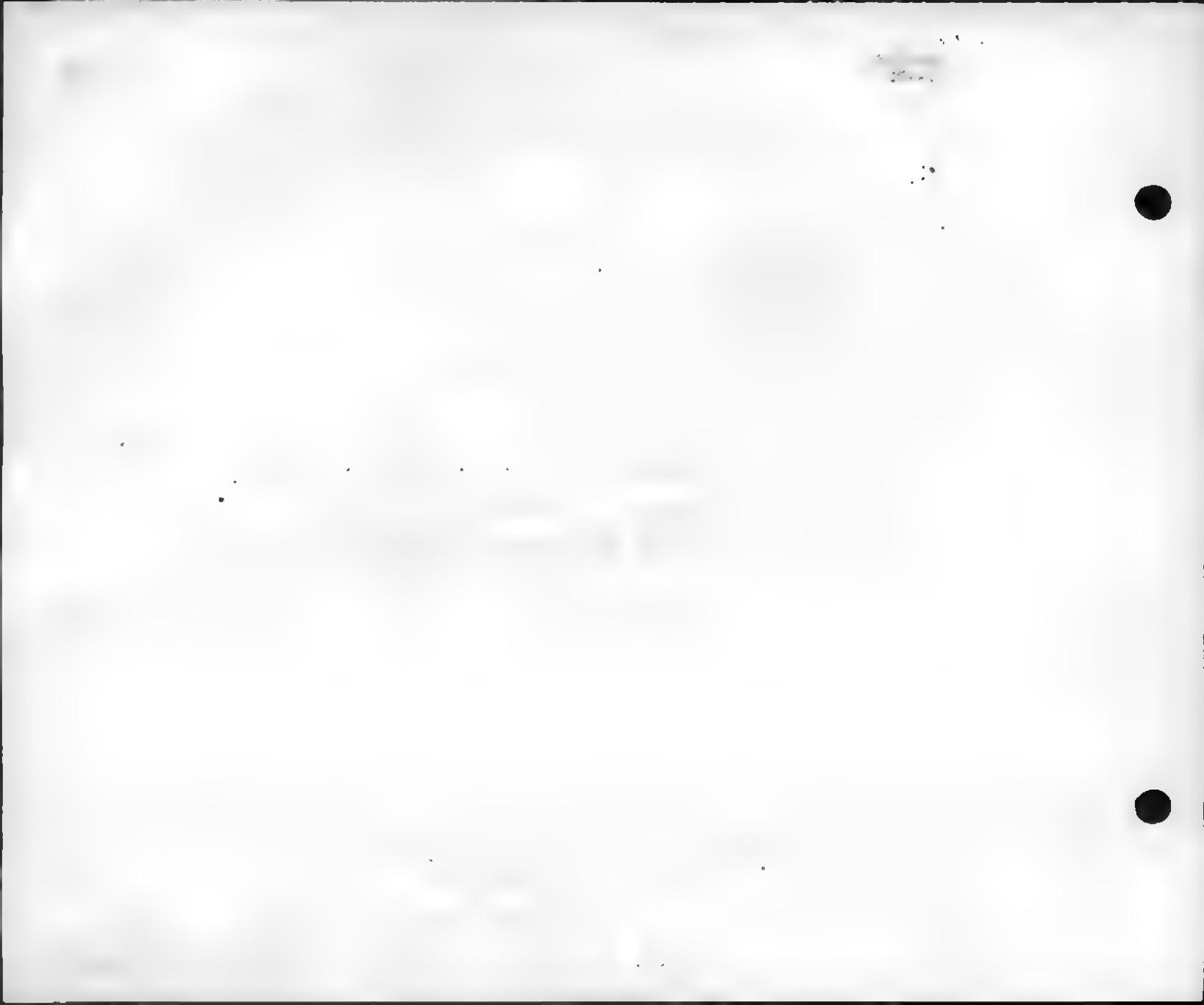
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06249

CERTIFICATE OF DEATH

5540

1. PLACE OF DEATH Baltimore County Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. Maryland				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN b Life		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e STREET ADDRESS 1101 Kenilworth Drive 21204		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First: Annie	Middle: L.	Last: De Prine	4. DATE OF DEATH	Month: 5 5 Day: 5 Year: 67 19			
S. SEX Female	6 COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/13/1889	9 AGE (in years lost birthday) 77 yrs	IF UNDER 1 YEAR Months: 0 Days: 0 Hours: 0 Min: 0	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Bauer		14. MOTHER'S MAIDEN NAME Marian D. Ellicot						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212 12 1661		17. INFORMANT 1101 Kenilworth Drive. Address D. Mr. John L. DePrine				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <u>4/2/61</u> (b) <u>Cerebral Arteriosclerosis with recent Cerebral</u> DUE TO (c) <u>Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 4/11, 19 67, to 5/5, 19 67, that (I) (we) last saw the deceased alive on 5/5, 19 67, and that death occurred at 3:50 p.m., from causes and on the date stated above.								
22a. SIGNATURE <u>Afraim S. Riggs</u>		22b. DATE SIGNED 5/5/67						
22c. PHYSICIAN'S NAME (Type) Afraim L.R. Riggs		22d. ADDRESS St. Joseph Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/67		23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		23d. LOCATION (City or Town) Baltimore Maryland		
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MD.		ADDRESS		25a. RECD BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
VR A15 (4) 20 M 1/66								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

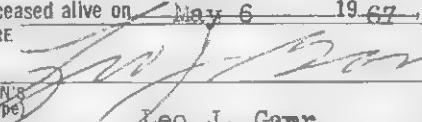
1621

excited within 24 hours ~~the~~ death.

ATTENDING PHYSICIAN: The law requires that the attending physician shall be present at all operations.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased died, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Catonsville		c. LENGTH OF STAY IN 10 20 Days		b. STATE Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Summit Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Rudolph	Middle H.	Last Dienhart	4. DATE OF DEATH Nov. 16, 1884	Month May	Day 9, 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH INDUSTRY Nov. 16, 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Transportation Clerk		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius J. Dienhart		14. MOTHER'S MAIDEN NAME Augusta E. Ehoff		Address Mrs. George E. Russell, Jr. 179 Southview Rd.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the hospital attended the deceased from Nov. 19, 1951, to May 19, 1967, that (I) was last saw the deceased alive on May 6 1967, and that death occurred at 4:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE 		22b. DATE SIGNED May 10, 1967					
22c. PHYSICIAN'S NAME (Type) Leo J. Gaer		22d. ADDRESS 1 Mallow Hill Ave., Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-12-1967		23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		23d. LOCATION (City, town or county) Baltimore, Md.	
24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 11 1967		25b. REGISTRAR'S SIGNATURE Charles J. Gaer	



FOR STATE
HEALTH DEPT.

is necessary,
please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DE242

1. PLACE OF DEATH a. COUNTY	Baltimore	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Baltimore	b. COUNTY	MD
c. LENGTH OF STAY IN lb	life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	St Joseph's Hospital	d. STREET ADDRESS	1654 E Belvedere
3. NAME OF DECEASED (Type or print)	FREDERICK	4. DATE OF DEATH	May 28 1967
First	Middle	Last	Month Day Year
5. SEX	Male	5. COLOR OR RACE	White
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	Dec 19 1897 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Ice Plant Employee	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME	Henry Dietz	14. MOTHER'S MARRIED NAME	Maryland USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give rank and date of service	No	16. SOCIAL SECURITY NO.	212-12-0683A
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	Mrs Louise Roth 1654 E. Belvedere Avenue		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Ambiguous	
(b)		Hyperlensive Arteriosclerotic Cardio	
(c)		Muscular Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Frank T. Kasik MD</i> SIGNED <i>5/29/67</i>		
EXAMINER'S NAME (Type)	FRANK T. KASIK MD	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>9005 Harkford Rd.</i>
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	5-31-1967	Gardens of Faith Cemetery	Baltimore Co. Md.
23. FUNERAL DIRECTOR	ADDRESS	(34)	24a. REC'D BY REGISTRAR
Lassahn Funeral Home	7401 Belair Road		24b. REGISTRAR'S SIGNATURE DATE MAY 31 1967 "orles judge"
VS. A15ME 5M 7/59			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06252

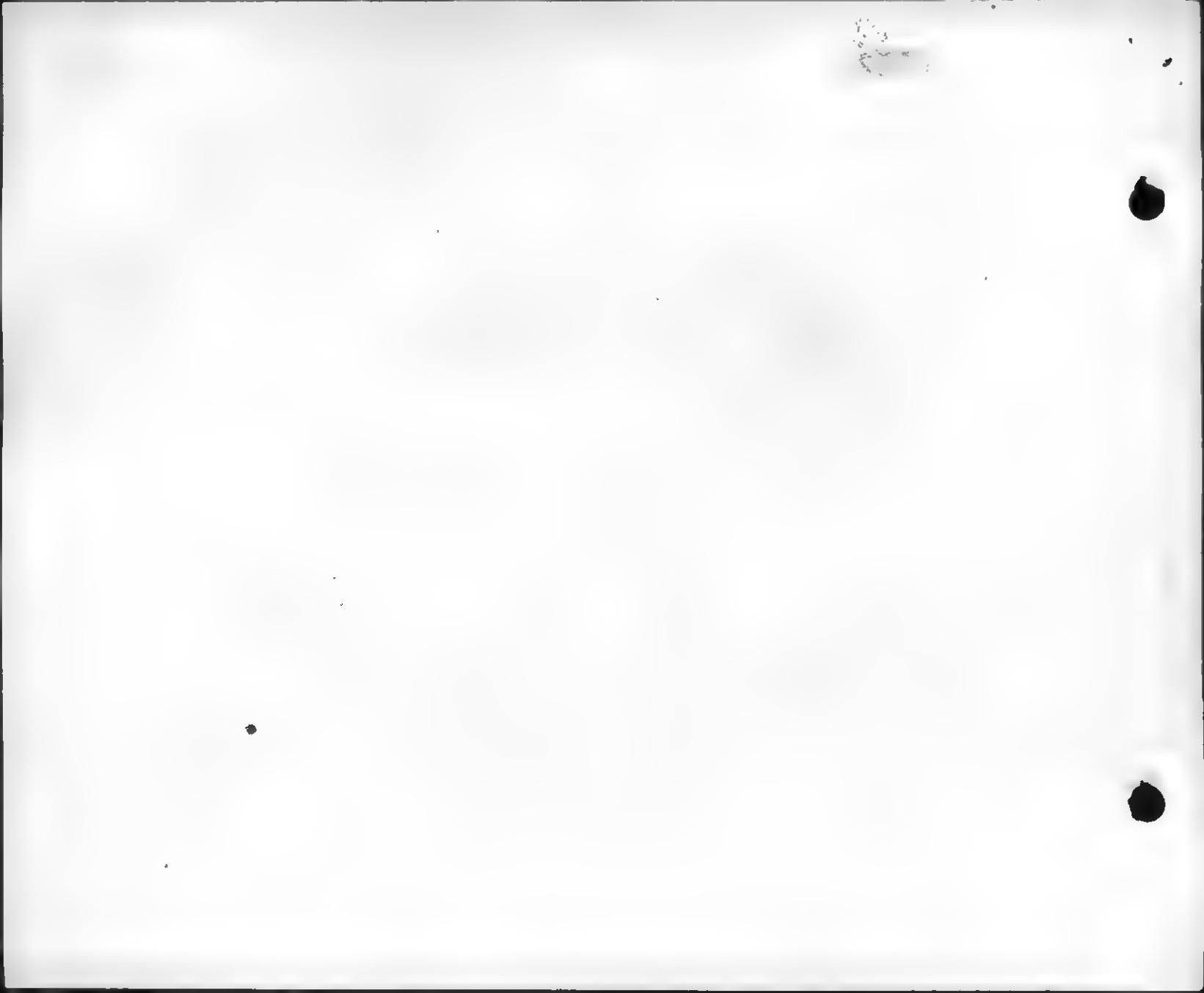
CERTIFICATE OF DEATH

30243

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland		
c. LENGTH OF STAY IN TB Towson			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 8007 Jacqueline Lane		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary		First Mary	Middle Lucille	Last DiFATTA	4 DATE OF May 16, 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1923	9. AGE (In years last birthday) 44 yrs	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME Benjamin J Rowland		14. MOTHER'S MAIDEN NAME Madge Ramsey		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Family RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic carcinoma of the breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c) Bronchopneumonia					
INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Towson (County) Md. (State) Md.					
21. I certify that (X) (this hospital) attended the deceased from April 28, 1967 , to May 16, 1967 , that (X) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 7:45 AM , from causes and on the date stated above.					
22a. SIGNATURE Miles E. St. John					
22b. DATE SIGNED May 16, 1967					
22c. PHYSICIAN'S NAME (Type) Miles St. John, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/67		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR CHAS. F. EVANS & SON, INC		ADDRESS Balto. Md.		25a. REC'D. BY REGISTRAR MAY 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Evans					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06253

Item #2a, b, c & d below, taken from any birth cert.		CERTIFICATE OF DEATH		06207	
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Balt. Medical Center		d. STREET ADDRESS 804 Apt. H Wilton Point Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Baby	Middle Bo-	Last Diggins	4. DATE OF DEATH May 7 1967	Month Day Year
5. SEX Male	6. COLOR OR RACE W	7. MARRIED WIDOWED	NEVER MARRIED NB	8. DATE OF BIRTH 5-7-67	9. AGE (in years) IF UNDER 1 YEAR last birthday Months Days Hours Min. 6 39
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Marvin Paul Diggins	14. MOTHER'S MAIDEN NAME Nancy Joan HARNER		Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY WITH PRIMARY APNOEA.
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) POSSIBLE TRISOMY 16-18					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 5-7-1967	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-7-1967 , to 5-7-1967 , that (I) (we) last saw the deceased alive on 5-7-1967 , and that death occurred at 8:40 PM , from the causes and on the date stated above.					
22a. SIGNATURE E.K. Narayanan		22b. DATE SIGNED 5-7-1967			
22c. PHYSICIAN'S NAME (Type) E. K. S. NARAYANAN		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	INTERN, GREATER BALTO-MED. CENTER
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 3/9/67	23c. NAME OF CEMETERY OR CREMATORIAL Greater Balt. Med. Ctr. Towson & Hill	23d. LOCATION (City, town or county) Towson	(State)
24. FUNERAL DIRECTOR John E. Adams, M.D.		ADDRESS 6 Bull St.	25a. RECEIVED BY REGISTRAR MAY 10 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE



Items 18&21 Film 389 6-1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

06254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16244

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with a farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY		2 USUAL RESIDENCE (Where deceased lived if institutional Residence before admission) a STATE Maryland b COUNTY Baltimore	
BALTIMORE MARYLAND		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Upperco P O	
d CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Upperco P O		c LENGTH OF STAY IN Tb Upperco P O	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dark Hollow Road		d STREET ADDRESS Dark Hollow Road	
3 NAME OF DECEASED (Type or print) ANDREW Andrew		4 DATE OF DEATH May 20 1967	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH April 10, 1894
9 AGE (in years days) 73 yrs	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY USA	13 FATHER'S NAME Unknown Diggs		
14 MOTHER'S MAIDEN NAME Annie Tucker	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16 SOC. SEC. # 217-24-7890	17 INFORMANT Mrs. Grace Thomas	Address Baltimore, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443 X Hypertensive and arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute bronchopneumonia			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) May 21, 1967		
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE OF DEATH May 24, 1967	23c NAME OF CEMETERY OR CREMATORIUM Piney Grove	23d LOCATION (City or Town) Boring Md. (County) (State)
24 FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.	ADDRESS	25a REC'D BY REGISTRAR MAY 25 1967 DA	25b REC'D STAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06255

16245

1. PLACE OF DEATH
a. COUNTY

BALTIMORE

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

CATONSVILLE

c. LENGTH OF STAY IN TB

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

SUMMIT NURSING HOME

3. NAME OF
DECEASED
(Type or print)

ELSIE

First

Middle

Last

4. DATE
OF
DEATH

May 10

1967

SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

WIDOWED DIVORCED

SEPT 1 1899 27 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (County & State, or foreign country)

WASH. DC.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

HERIBERT GORDON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

MRS.

Address

THORN #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

Cerebral Thrombosis 1st

Diabetes Mellitus

Emphysema Pr (mildly)

Arteriosclerotic Cardio Vas Cul (2)

DIABE

INTERVAL BETWEEN
ONSET AND DEATH

40 days

3 yrs. s.

57 days.

54 days

54 days

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....

4/18/67

5/1/67

, 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....

5/9/67

, and that death occurred..... P.M. from the causes and on the date stated above

22a. SIGNATURE

McGraw

22c. PHYSICIAN'S NAME (Type)

WE McGraw

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

5/11/67

22b. DATE SIGNED

22d. ADDRESS

1303 Frederick Rd Catonsville 28 MD

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)

CREMATION MAY 12 1967

23b. DATE THEREOF

FORT LINCOLN CEM. PRINCE GEO. CO. MD.

23d. LOCATION (City, town or county)

MD.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

JOHN M. TAYLOR SON ANAPOLIS MD.

25a. REC'D BY REGISTRAR

MAY 15 1967

25b. REGISTRAR'S SIGNATURE

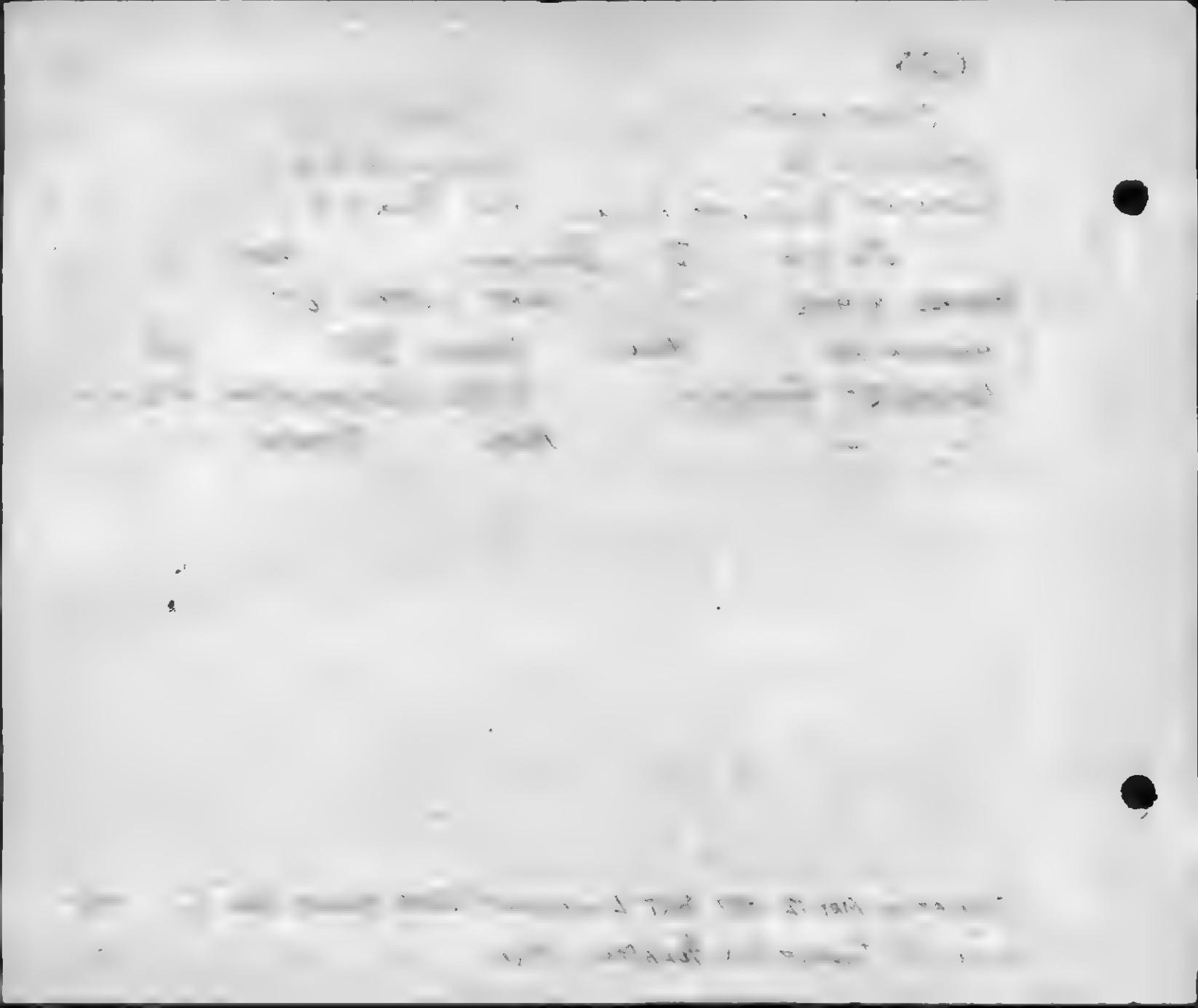
Charles Judge

DATE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be used as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7-62



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute a certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Funeral Director. Page 3 should be used as a burial permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
SM 1/62

FOR STATE
HEALTH DEPT.

DEPT. OF
MEDICAL EXAMINERS

BALTIMORE CITY

MD 21201

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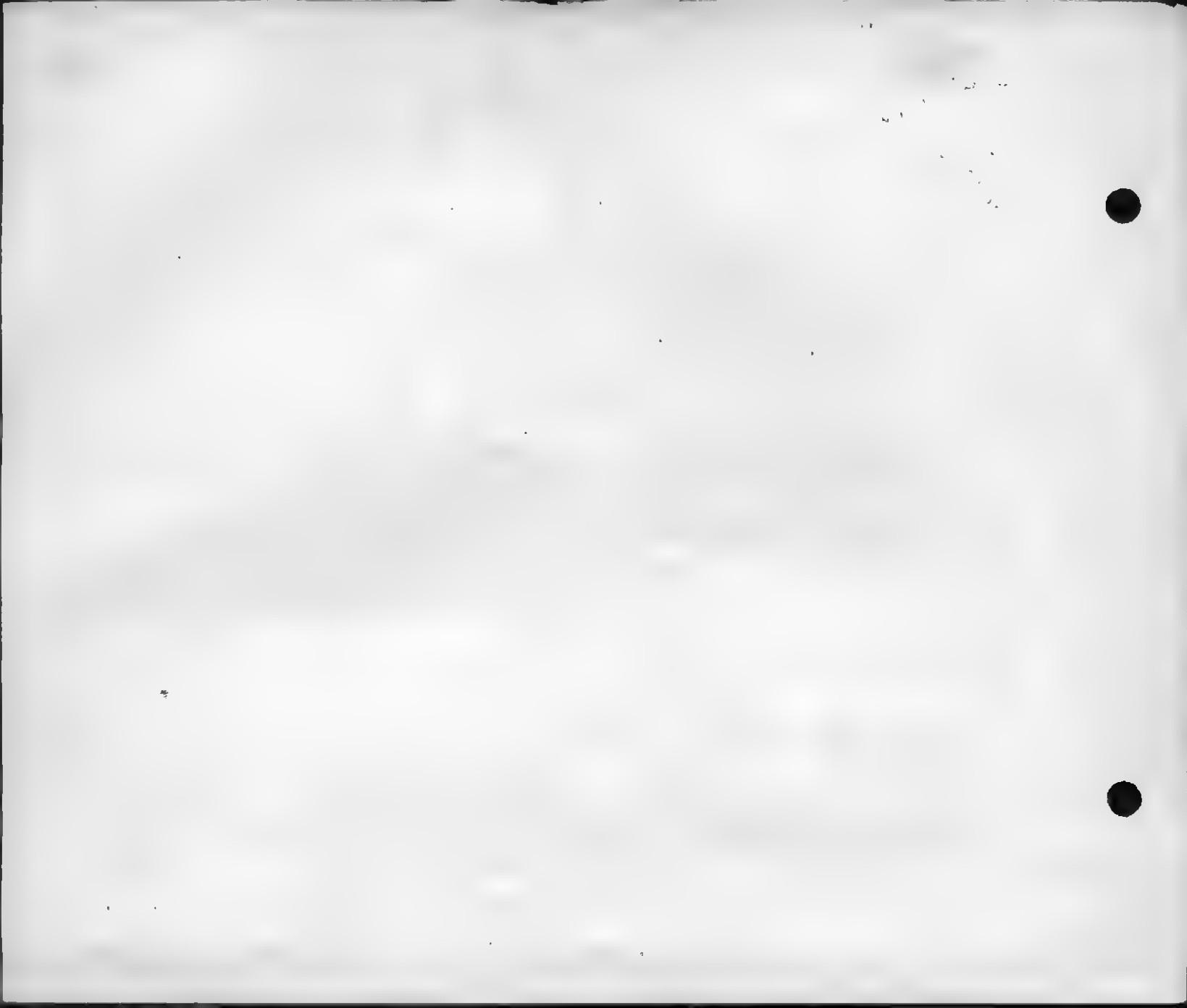
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06257

CERTIFICATE OF DEATH

06257

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Maryland Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Half a month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		d. STREET ADDRESS 1627 N. LEXINGTON ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle N MN	Last Early
4. DATE OF DEATH	Month 5	Day 20	Year 1967
5. SEX Male	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12-03-31
9. AGE (In years last birthday) 13 yrs	10. BIRTHPLACE (County & State, or foreign country) ROOFERSVILLE TENN.	11. CITIZEN OF WHAT COUNTRY? U.S.	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman	10b. KIND OF BUSINESS OR INDUSTRY Retail Dairy	12. MOTHER'S MAIDEN NAME Mandy STUBLEY	
13. FATHER'S NAME THOMAS EARLY (Deceased)	14. MOTHER'S MAIDEN NAME Lula B. Early - same as #2 above	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO 408-28-4828			
17. INFORMANT ca. Lung			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-9-67 to 5/20/67 , that (I) (we) last saw the deceased alive on 5/20/67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Ram K. Chhillar		22b. DATE SIGNED 5/20/67	
22c. PHYSICIAN'S NAME (Type) Ram K. CHHILLAR	22d. ADDRESS GTR. BALTO. MED. CENTER		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/23/67	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis Anne Arundel Md.
24. FUNERAL DIRECTOR Beverley E. "Oppen" Hopping Funeral Home	ADDRESS Annapolis, Md.	25a. REC'D BY REGISTRAR MAY 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

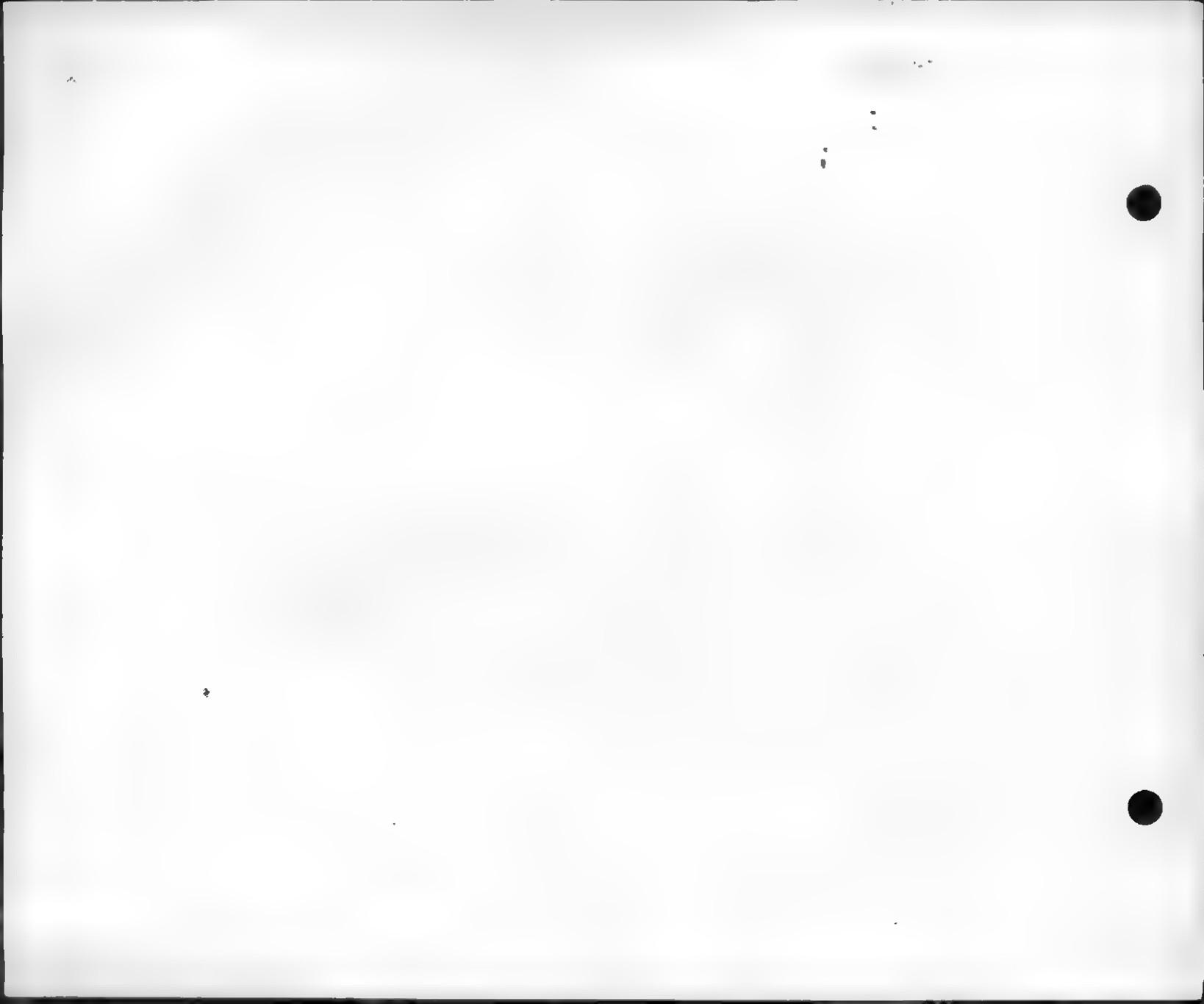
Page 4 may be retained by the hospital or attending physician.
■ FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06258

CERTIFICATE OF DEATH

UE248

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND			2. USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE Md b. COUNTY BALTO		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT HOME			d. STREET ADDRESS 2119 ARLONNE DR.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First REA	Middle HOOPER	Last EDGAR SR.	4. DATE OF DEATH MAY 13 1967
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 6/22/91	9. AGE (In years, last birthday) 75 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY RET.	11. BIRTHPLACE (County & State, or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William EDGAR		14. MOTHER'S MAIDEN NAME MAMIE REA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO 212 10 6420	17. INFORMANT HELEN EDELMANN	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia due to DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerosis coronary disease DUE TO (c) Generalized arteriosclerosis					
INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) March 1967	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1967 to 13 May 1967 , that (I) (we) last saw the deceased alive on 13 May 1967 , and that death occurred at M , from causes and on the date stated above.					
22a. SIGNATURE William J. Bryson		22b. DATE SIGNED 15 May 67			
22c. PHYSICIAN'S NAME (Type) E.S. MALNABR JR.		MD ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. ADDRESS 301 FREDERICK RD. BALTO, CO. MD 21228
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/16/67	23c. NAME OF CEMETERY OR CREMATORIAL LORRAINE	23d. LOCATION (City or Town) (County) (State) BALTO, CO. MD	
24. FUNERAL DIRECTOR E.S. MALNABR JR.		25a. ADDRESS 301 FREDERICK RD. BALTO, CO. MD 21228	25b. REC'D BY REGISTRAR MAY 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT

11/14/67

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

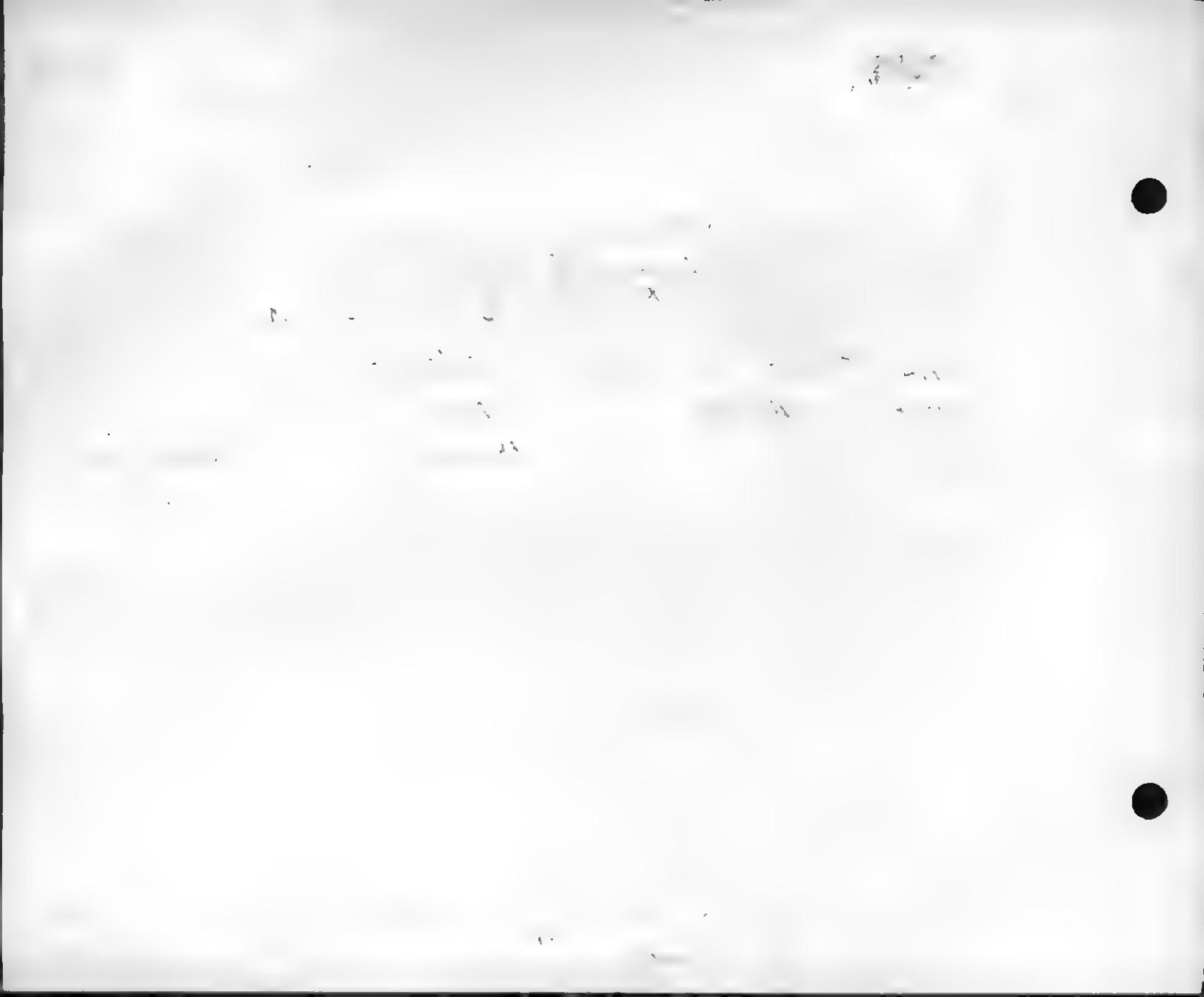
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

38249

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY .N lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hillendale Country Club		d. STREET ADDRESS 1202 Cherry Hill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILL LEONARD	Middle ELLERBE	4. DATE OF DEATH May 11 19 67
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1926
9. AGE (in years last birthday) 41 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffeur		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (State or foreign country) ELLERBE, N.C.		12. CITIZEN OF WHAT COUNTRY? MINNESOTA	
13. FATHER'S NAME Joshua Ellerbe		14. MOTHER'S MAIDEN NAME Address Minnie Hines <i>Lydia Ellerbe 1202 Cherry Hill Rd</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Lydia Ellerbe		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive and Arteriosclerotic Cardiovascular Disease. 443A (b) Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (c)	
19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg etc.)		20f. (City or town), (County), (State)	
21. ACTUAL SIGNATURE <i>Charles S. Petty</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Charles S. Petty	
22. DATE SIGNED 5/11/67			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/67	
23c. NAME OF CEMETERY OR CREMATORIUM Coryell Mem. Park Laurel		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Milton E. Ellickson N. Carolina		25a. ADDRESS 1129	
		25b. REC'D BY REG. STAR DATE MAY 12 1967	
		25c. REGISTRAR'S SIGNATURE Charles S. Petty	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 4 Form 39 5/29/67 kk											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a COUNTY BALTIMORE				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND							
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE				c LENGTH OF STAY IN TB MARYLAND				b COUNTY BALTIMORE			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 16 E. SEMINARY AVE.				e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE				d. STREET ADDRESS 16 E. SEMINARY AVE.			
3. NAME OF DECEASED (Type or print) ANNA				First E.	Middle ENDERS	Lost 1	4 DATE OF DEATH MAY 1, 1967	Month MAY	Doy 1	Year 1967	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB. 1 - 1895	9 AGE (In years lost birthday) 72 yrs	IF UNDER 1 YR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0		
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSEWIFE				10b KIND OF BUSINESS OR INDUSTRY OWN HOME	11 BIRTHPLACE (County & State or foreign country) Maryland	12 CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Charles Wells - (Step Father)				14 MOTHER'S MAIDEN NAME Henrietta E. Wells				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. NONE	17 INFORMANT Family Records									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH DUE TO Severe months											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Diabetes & arteriosclerosis C.V. Disease											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral thrombosis											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) 1				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c TIME OF INJURY Month, Day, Year Hour : o.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Many years	20f (City or town) Towson	(County) Md.	(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from many years , 19____, that (I) (we) last saw the deceased alive on Apr 29 1967 , and that death occurred at M , from causes and on the date stated above.											
22a SIGNATURE George McLean				22b DATE SIGNED 5/4/67							
22c PHYSICIAN'S NAME (Type) GEORGE MCLEAN				22d ADDRESS 705 Med Act's Bldg							
23a BURIAL, CREMATION, REMOVAL (Specify) May 5, 1967		23b DATE THEREOF May 5, 1967	23c NAME OF CEMETERY OR CREMATORIAL Prospect Hill Cemetery				23d LOCATION (City or Town) Towson, Md.				
24 FUNERAL DIRECTOR John Burns' Sons, Towson, Md.		ADDRESS				25d REC'D BY REG STRAR MAY 8 1967		25e REGISTRAR'S SIGNATURE Charles J. Jones			
VR A15 (4) 25M 1/67											



FOR STATE
HEALTH DEPT.

M

1

Delay is
in pencil in item 1a. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

I

1

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death If necessary, please execute this certificate, writing the word "pending" in pencil in item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit file pages 1 and 2 with the State Department of Health is pending.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

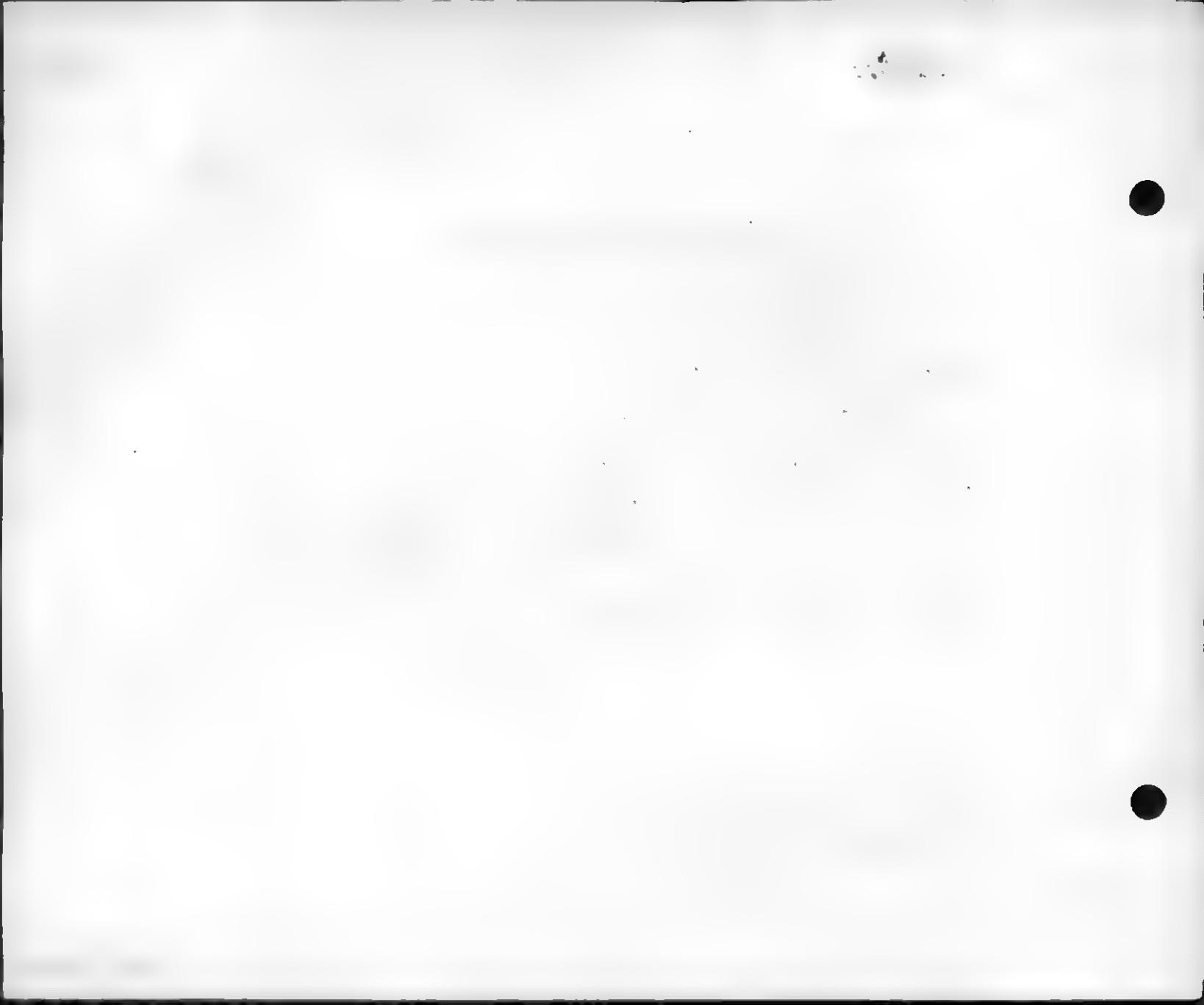
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

JEB251

06261

1 PLACE OF DEATH a COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MD.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE-RIVER		c LENGTH OF STAY IN b 30 yrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2200 OLD OREMS Rd.		d STREET ADDRESS 2200 OLD OREMS Rd.	
3 NAME OF DECEASED (Type or print) HARRY		First CHARLES	Middle EVANS SR
4 DATE OF DEATH MAY 10	Month 1967	Day 1967	Year
5 SEX MALE	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-1894
W DIVORCED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 AGE (In years last birthday) 72 yrs	F UNDER 1 YEAR Months 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER-BCT MARTIN - CO	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) MD	12 CITIZEN OF WHAT COUNTRY A.S.A.
13 FATHER'S NAME HARRY C EVANS		14. MOTHER'S MAIDEN NAME WERNER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) Yes WWI		16 SOCIAL SECURITY NO 216-10-6063A	17 INFORMANT FLORENCE EVANS
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b)		INTERVAL BETWEEN ONSET AND DEATH Coronary Occlusion A-S-D-V Disease	
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) W/H		
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) MD	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City or town) MD		
EXAMINER'S NAME (Type) M. B. DAVIS	22 DATE SIGNED 5/11/67		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 5/13/67	23c NAME OF CEMETERY OR CREMATORIAL PARKWOOD Cem.	23d LOCATION (City or Town) (County) (State) BALTO MD.
24 FUNERAL DIRECTOR J. G. CONNELLY SONS	25a ADDRESS 300 MACE	25b REC'D BY REG STRR MAY 15 1967	26b REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06252

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M 06262		CERTIFICATE OF DEATH						06252				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE Virginia									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 14 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halifax									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph, Hospital			d. STREET ADDRESS Rt #1, Box 568			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) ANNIE MAUDE FARMER		First ANNIE	Middle MAUDE	Last FARMER	4. DATE OF DEATH 11-26-94	Month May	Day 26	Year 19 67				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED Divorced	9. DATE OF BIRTH 72		9. AGE (In years, last birthday) yrs	10. UNDER 1 YEAR Months 0	10. UNDER 24 HRS Days 0	10. UNDER 24 HRS Hours 0	10. UNDER 24 HRS Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lee Divers					14. MOTHER'S MAIDEN NAME Martha Dillon							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO			17. INFORMANT			Address H. Melvin Farmer 1410 Tenbury Rd. 21903			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro vascular thrombosis, right cerebral artery DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Possible pulmonary embolism and infarction DUE TO (c)											INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 5-12 1967 to 5-26 1967 , that (I) (we) last saw the deceased alive on 5-26 1967 , and that death occurred at 4:35 P.M. from causes and on the date stated above.											22b. DATE SIGNED 5-26-67	
22a. SIGNATURE <i>Fiorella G. Malit, M.D.</i>			22d. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22e. ADDRESS 7620 York Road, Baltimore, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/29/67		23c. NAME OF CEMETERY OR CREMATORIUM Pleasant Grove Cemetery			23d. LOCATION (City or Town) (County) (State) Halifax, Va.					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204					25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36263

CERTIFICATE OF DEATH

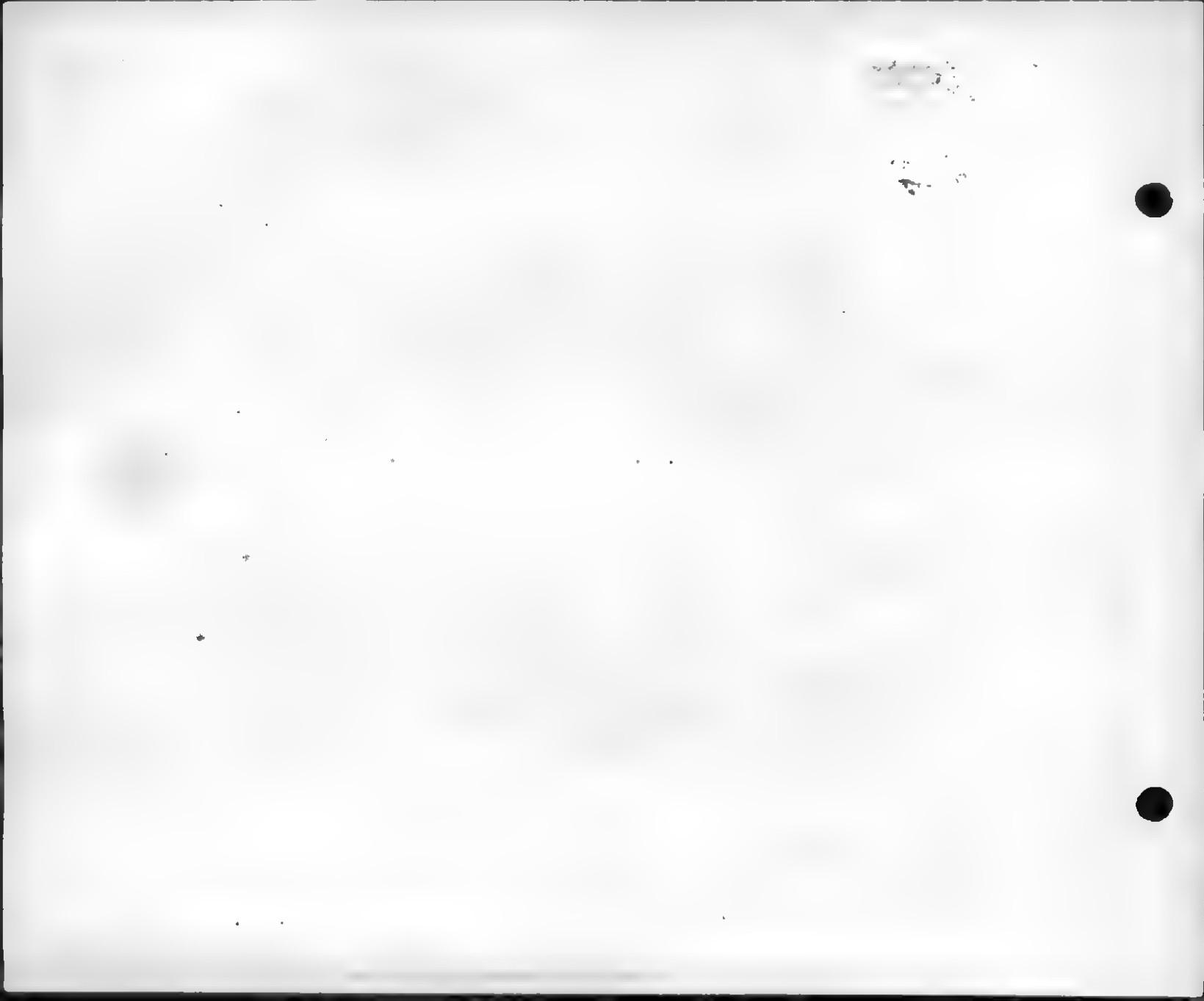
18253

Item 2 Film (330)

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb <i>16 MONTHS</i>		13 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>MARYLAND</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Silver Spring Nursing Home</i>		e. STREET ADDRESS <i>2279 Park Hill Avenue</i>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <i>MARY</i>		First	Middle	Last	4 DATE OF DEATH <i>MAY 4 1967</i>	Month	Day	Year	
5 SEX <i>FEMALE</i>	6 COLOR OR RACE <i>Cau</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>2/27/1887</i>	9 AGE (In years last birthday) <i>80 yrs.</i>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <i>Unknown</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>UNKNOWN</i>		14 MOTHER'S MAIDEN NAME <i>Unknown</i>		Annie Kline					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>W. D.123-038</i>		17. INFORMANT Linthicum, Md. Address Mr. Melvin F. Fauble 516 Springer Court					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>441X</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Maligant colo rectal carcinoma.</i>		INTERVAL BETWEEN ONSET AND DEATH					
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Aspirin & Phenacetin.</i>		(c) DUE TO <i>Aspirin & Phenacetin.</i>							
19. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>May 4 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>8155 Loch Raven Blvd.</i>		20f. (City or town) (County) (State) <i>Baltimore</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>8/126</i> , 19 <i>66</i> , to <i>2/14</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5/4/67</i> , 19 <i>67</i> , and that death occurred at <i>11:30A.M.</i> from causes and on the date stated above.		22a. SIGNATURE <i>Arthmo M. Schwab</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/4/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Arthmo M. Schwab</i>		22d. ADDRESS <i>8155 Loch Raven Blvd.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 6, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore</i>			
24. FUNERAL DIRECTOR <i>G. Truman Schwab 3512 Frederick Ave, Baltimore, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>MAY 8 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top two corners of the paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06264

CERTIFICATE OF DEATH

06254

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN Tb 7 days		c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center			d. STREET ADDRESS 7524 Belair Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOSEPH FRANK FAULSTICH		First JOSEPH	Middle FRANK	Last FAULSTICH	4. DATE OF DEATH Month May Day 16 Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/20/16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Maritime Adminis.		9. AGE (In years last birthday) 51 yrs	
13. FATHER'S NAME Henry Faulstich		14. MOTHER'S MAIDEN NAME Steidle Caroline		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 215-05-5260		17. INFORMANT Patient's Chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure due to INTERVAL BETWEEN ONSET AND DEATH 2 days DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c)					
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	
20f. (City or town) Taylor Avenue		(County) Balto Md.		(State)	
21. I certify that (I) (this hospital) attended the deceased from 5/9/1967 to 5/16/1967 , that (I) (we) last saw the deceased alive on 5/16/1967 , and that death occurred at 9:27AM , from causes and on the date stated above.					
22a. SIGNATURE <i>John E. Adams</i> 22b. DATE SIGNED May 16, 1967					
22c. PHYSICIAN'S NAME (Type) Daniel F. Negrete		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
22d. ADDRESS Greater Baltimore Medical Center					
23a. BURIAL CREMATION, (Check one) Burial		23b. DATE THEREOF May 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION (City or Town) Taylor Avenue		(County) Balto Md.		(State)	
24. FUNERAL DIRECTOR DIPPEL BROS INC 7110 BELAIR ROAD		ADDRESS		25a. REC'D BY REGISTRAR DA	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE MAY 18 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06265

CERTIFICATE OF DEATH

OP 255

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverview		c. LENGTH OF STAY IN 1b Riverview	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 914 Winsap Court, Riverview, Md. 21227		e. STREET ADDRESS 914 Winsap Court	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle J.	Last Faulstich
4. DATE OF DEATH May 12 1967	Month May	Day 12	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/92
9. AGE (In years last birthday) yrs 75	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. DOB. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter	14. KIND OF BUSINESS OR INDUSTRY Retired	15. BIRTHPLACE (County & State, or foreign country) Maryland	16. CITIZEN OF WHAT COUNTRY? USA
17. FATHER'S NAME John Faulstich		18. MOTHER'S MAIDEN NAME Unknown	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		20. SOCIAL SECURITY NO. 213-05-5091	21. INFORMANT Mrs. Herma C. Parsons
		Address 914 Winsap Court	
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Generalized Carcinoma from Large Bowel			
DUE TO (c) Large Bowel			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
23a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
23c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		23d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	23e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3915 HOLLINS FERRY RD.
		23f (City or Town) BALTO., Md.	(County) 21227
		(State)	
24. I certify that (I) (this hospital) attended the deceased from Jan. 30, 1967 to May 12, 1967 , that (I) (we) last saw the deceased alive on May 12 1967 , and that death occurred at 8:00 AM , from causes and on the date stated above.			
25. SIGNATURE Domingo C. Sorongon		M.D. ATTENDING PHYS. DOMINGO C. SORONGON, M.D.	22b. DATE SIGNED 5/13/67
26. PHYSICIAN'S NAME (Type) DOMINGO C. SORONGON, M.D.		22d. ADDRESS 3915 HOLLINS FERRY RD.	
27. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland
28. FUNERAL DIRECTOR Howard H. Hubbard		23e. ADDRESS 4107 Wilkens Ave.	23f. REC'D BY REGISTRAR 21229 MAY 15 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

14



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

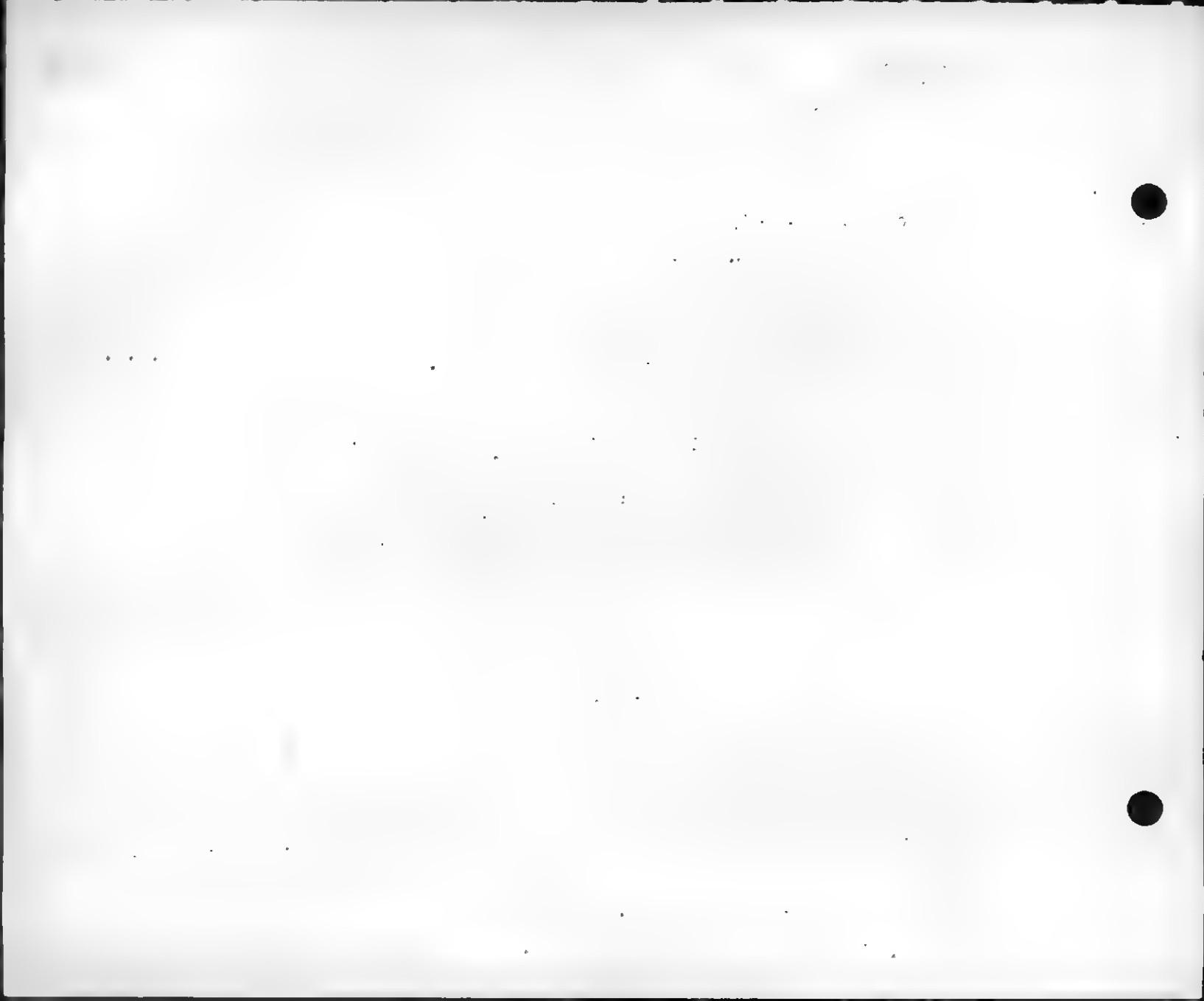
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

JS256

06266

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE 820 Belnord Ave b. COUNTY 21224 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Md	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Middle Last	4. DATE OF DEATH	Month Day Year
Leo B Filipiak		May 6	1967 19
5. SEX M/W	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9 22 10
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roll Shop Helper		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stefan		14. MOTHER'S MAIDEN NAME Josephine Bender	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213 07 7070	17. INFORMANT Mrs. Florence Filipiak Address same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			
DUE TO (b) A-S-C-V. Disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B.Daw		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, City, County, State) 5220 Belnord Ave. Baltimore Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5 11 67	
23c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Raymond L. Kaczorowski		ADDRESS 2525 Fleet St. 21224	
25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
36267

CERTIFICATE OF DEATH

06257

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. This page remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville 21087		d. STREET ADDRESS Bellvue Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Mary	Middle G.	4. DATE OF DEATH FITZPATRICK	Month May	Doy 16, 19 67	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1899	9. AGE (In years lost birthday) 68 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CIT ZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Field				14. MOTHER'S MAIDEN NAME Margaret Parrish		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-38-7693		17. INFORMANT Margaret F. Langrehr		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Myocardial infarction with aneurysmal dilation of the heart (c)	
						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
20e. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 10, 1967 , to May 16, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 9:30 M. , from causes and on the date stated above		22e. SIGNATURE Juana S. Cockburn		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22f. DATE SIGNED May 17, 1967	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE THEREOF May 19, 1967		23c. NAME OF CEMETERY OR CREMATORIUM St. Francis Cemetery Abingdon, Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR The Dippel Bro's Inc. 7110 Belair Rd.		ADDRESS		25a. REC'D BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

May is
H 340
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18. Give Pages 1, 2, and 3 along with form PM3

CERTICAL EXAMINER: This certificate should be executed within 24 hours after you execute the certificate, writing the word "pending" in pencil in Item 11. **CHIEF MEDICAL EXAMINER'S OFFICE:** Page 4 should be forwarded to the Chief Medical Examiner's Office and far your files.

TO DEPUTY MEDICAL EXAMINER: If necessary, please execute the certificate of the funeral director. Page 4 should be retained for your files.

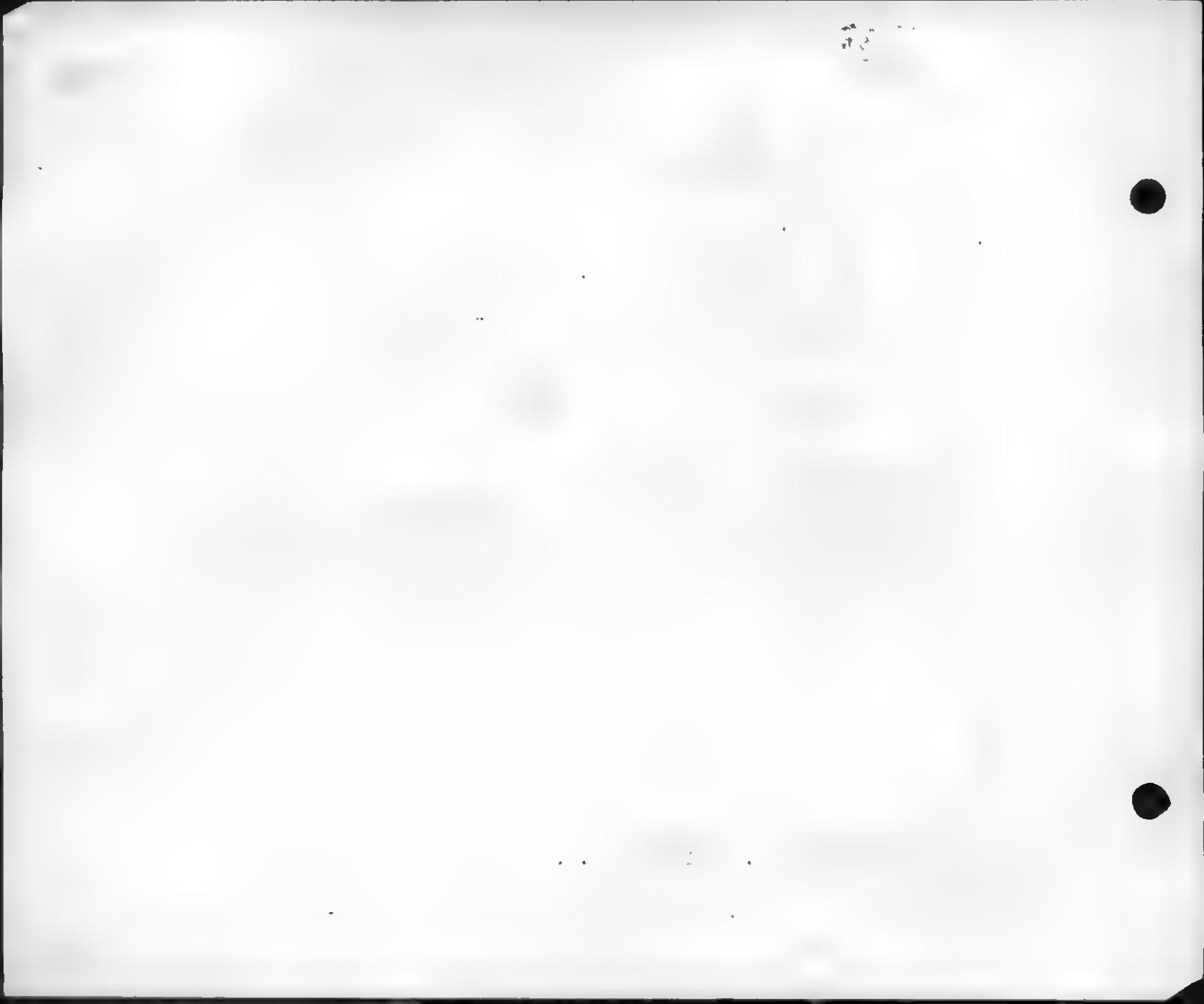
VR A15ME (5)
6M 1/67

06263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11059

1 PLACE OF DEATH a COUNTY		BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Reside re before admission a STATE		Maryland b COUNTY BALTIMORE		
b CITY OR TOWN (If outside corporate write RURAL and give nearest town) Baltimore Middle River Belair		c LENGTH OF STAY IN 16 15 min.		c CITY OR TOWN (If outside corporate write RURAL and give nearest town) Belair		d CITY OR TOWN (If outside corporate write RURAL and give nearest town) Hays 108 Haynes Street		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 43 W. Hicham Road				d. STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)		First JAMES	Middle D.	Last FLANAGAN	4 DATE OF DEATH	Month May	Day 21,	Year 19 67
S SEX	6. COLOR OR RACE	7 MARR ED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH	9 AGF (In years last birthday) 23 yrs	10 UNDR 1 YR Months	FUNDR 24 HRS Days Hours Min	
Male	White	W DOWED <input type="checkbox"/>	D VORCED <input checked="" type="checkbox"/>	6-25-43				
10a U.S. AL OCCUPATION (Give kind of work done during most of working life, even if ret red) Clerk		10b KIND OF BUSINESS OR INDUSTRY loan Co.		11 BIRTHPLACE (State or foreign country) Austinville, Va.		12 CIT ZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Steve Flanagan				14. MOTHER'S MAIDEN NAME Bertha M. Shupe				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		16. SOCIAL SECURITY NO 229-54-7997		17. INFORMANT		Address Steve Flanagan, Austinville, Va.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contact gunshot wound of head DUE TO 976X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCR BE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18, Shot self in head						
20c TIME OF INJRY Month, Day, Year about a.m. 3:00 PM 5-21 19 67		20d INJRY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJRY (Home, farm factory, street, office bldg, etc.) home	20f (City or town) -	(County) Baltimore	(State) Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county) Charles S. Sprangate, M.D.						
22. DATE SIGNED May 21, 1967								
23a BUR AL CREMATION, REMOVAL (Specify) Removal		23b DATE THEREOF May 23, 1967	23c NAME OF CEMETERY OR CREMATORI Vauhan, Gwynn, McGrady F.H. Hillsville		23d LOCATION (City or Town) Hillsville	(County) Carroll (State) Va		
24 FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		ADDRESS	25a MAY 24 1967		25b RELEASER'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08259

1
96269

CERTIFICATE OF DEATH

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 hours after death.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md., 21213 b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CHAPELL HILL NURSING HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First A. Middle FORD		d. STREET ADDRESS 3444 Belair Road	
4. DATE OF DEATH 9 PM 5	Month 5	Day 24	Year 1967
5. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
9. AGE (In years last birthday) 62 yrs.		10. DATE OF BIRTH 12/4/04	
11. BIRTHPLACE (Country & State, or foreign country) National Stationery Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Oliver Ford		14. MOTHER'S MAIDEN NAME Fannie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Ford, Brother, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C. A. of Pancreas = Generalized Metastases</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-1-1967 to 5-24-1967, that (I) (we) last saw the deceased alive on 5/24/1967, and that death occurred at 8:55 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Cesar Valle Covero</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/24/67
22c. PHYSICIAN'S NAME (Type) CESAR VALLE COVERO		22d. ADDRESS 8629 Liberty Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/67	
23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery		23d. LOCATION (City or Town) Baltimore, Md. (County) (State)	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. RECEIVED BY REGISTRAR MAY 26 1967	
		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

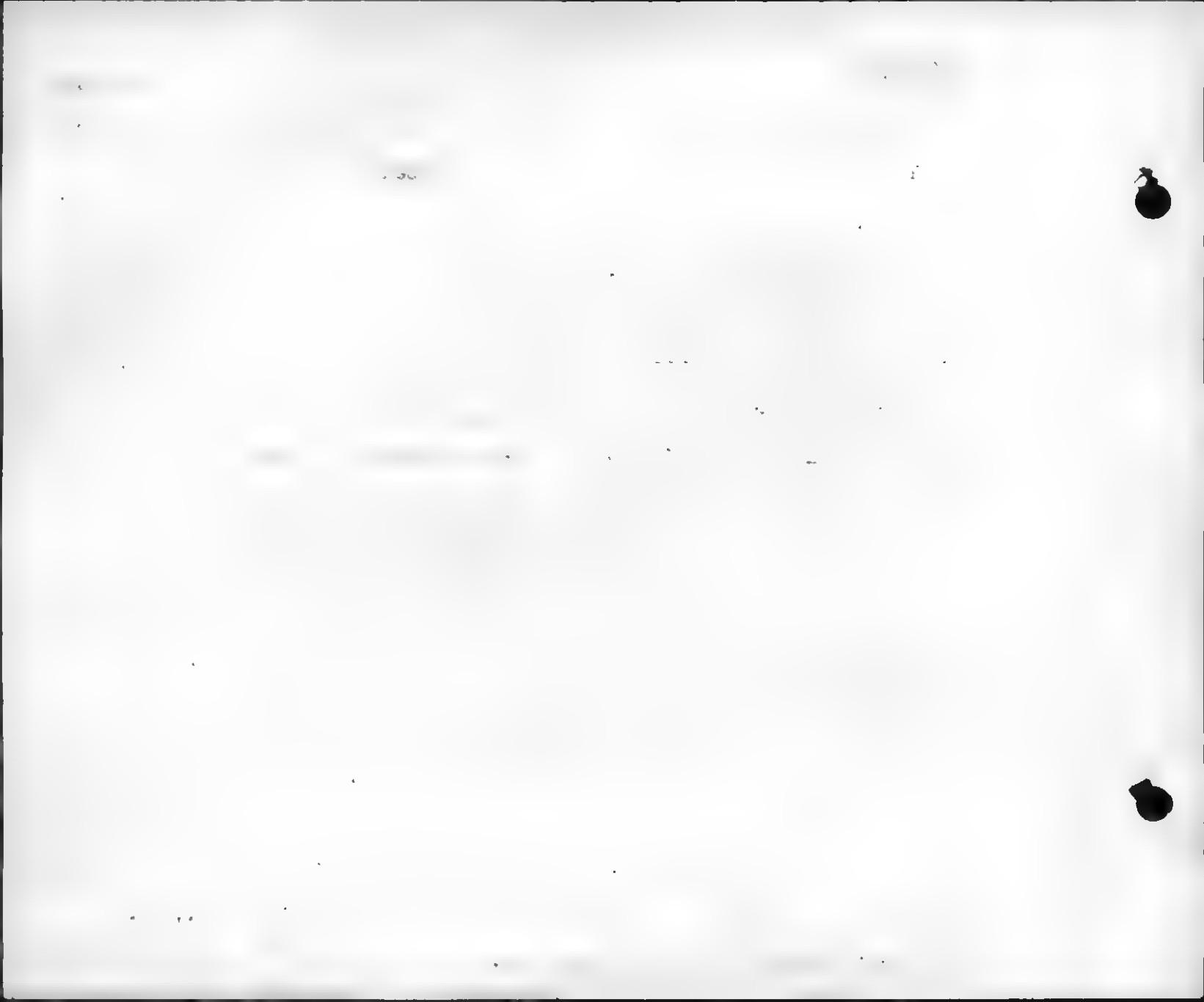
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06270

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Essex 21221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 701 Norris Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Romana (Mina)	Middle L.	Last Friedel
4. DATE OF DEATH	Month May	Month 17	Day Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 9-9-05	9. AGE (in years last birthday) 61 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (County & State, or foreign country) Austria	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Conrad Gourb	14. MOTHER'S MAIDEN NAME Matilda ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 216 56 7299	17. INFORMANT Charles Friedel	Address Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Myocardial infarction - 1 week duration (c) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from May 17, 1967 to May 17, 1967 , that <input type="checkbox"/> (we) last saw the deceased alive on May 17, 1967 , and that death occurred at 5:45 PM from causes and on the date stated above.			
22a. SIGNATURE Juana S. Cockburn	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22b. DATE SIGNED 5-18-67			
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.	22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/22/67	23c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart of Jesus	23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.
24. FUNERAL DIRECTOR Janice J. Buzdzinski	- ADDRESS Buzdzinski Funeral Home 1407 Eastern Ave.		25a. REGISTRATION NUMBER 154182 25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

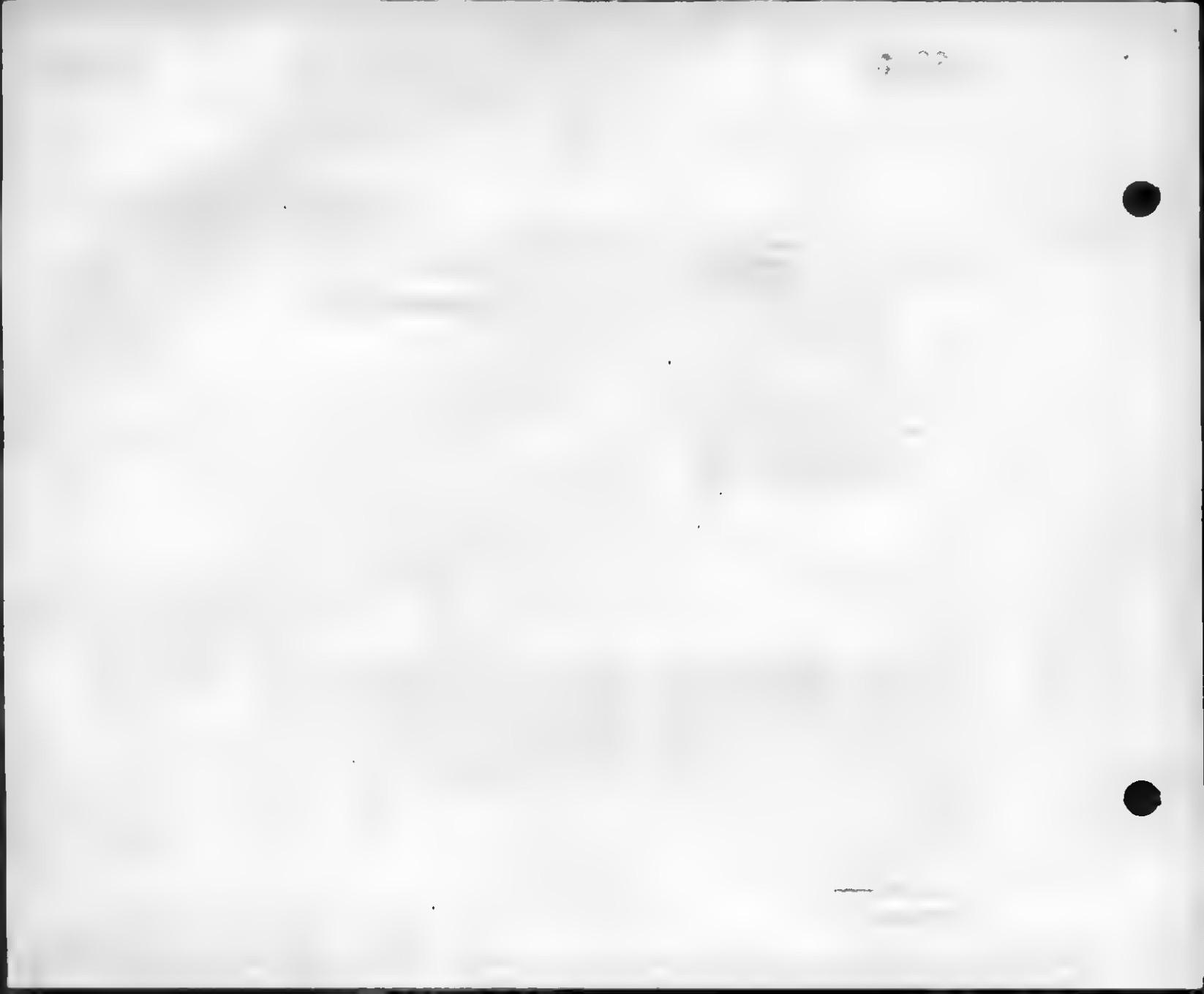
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06271 1 CDS 1

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204		c. LENGTH OF STAY IN 1b 1 week		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Towson Nursing Home		d. STREET ADDRESS 940 OL' STEAD ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle MONROE	Last Frohsin	4. DATE OF DEATH May 4 1967	Month May	Day 4	Year 1967		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH UNKNOWN	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY MFG. REPRESENTATIVE		11. BIRTHPLACE (County & State, or foreign country) Atlantic City, N.J.					
13. FATHER'S NAME Samuel Frohsin		14. MOTHER'S MAIDEN NAME Lowella Snellenberg							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Dulaney Towson Nursing Home, 111 West Road		Address Baltimore, 21204			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Generalized melanoma with brain metastasis									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) melanoma DUE TO (b) melanoma INTERVAL BETWEEN ONSET AND DEATH 6 weeks Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c) melanoma 6 yrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19 ⁶⁷ , to _____, 19 ⁶⁷ , that (I) (we) last saw the deceased alive on _____, 19 ⁶⁷ , and that death occurred at _____ P.M., from the causes and on the date stated above.		22b. DATE SIGNED 5/4/67							
22a. SIGNATURE Jonas H. Cohen		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 6107 Park Heights Ave., BALTIMORE 21215					
23a. BURIAL, CREMATION, REMOVAL (specify) Burial		23b. DATE THEREOF 5/11/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS WOODLAWN PARK CREMATORIAL		23d. LOCATION (city, town or county) (State) FREDERICK AVENUE			
24. FUNERAL DIRECTOR Solomon Bros. F.F.						25a. REC'D BY REGISTRAR MAY 11 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE									



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

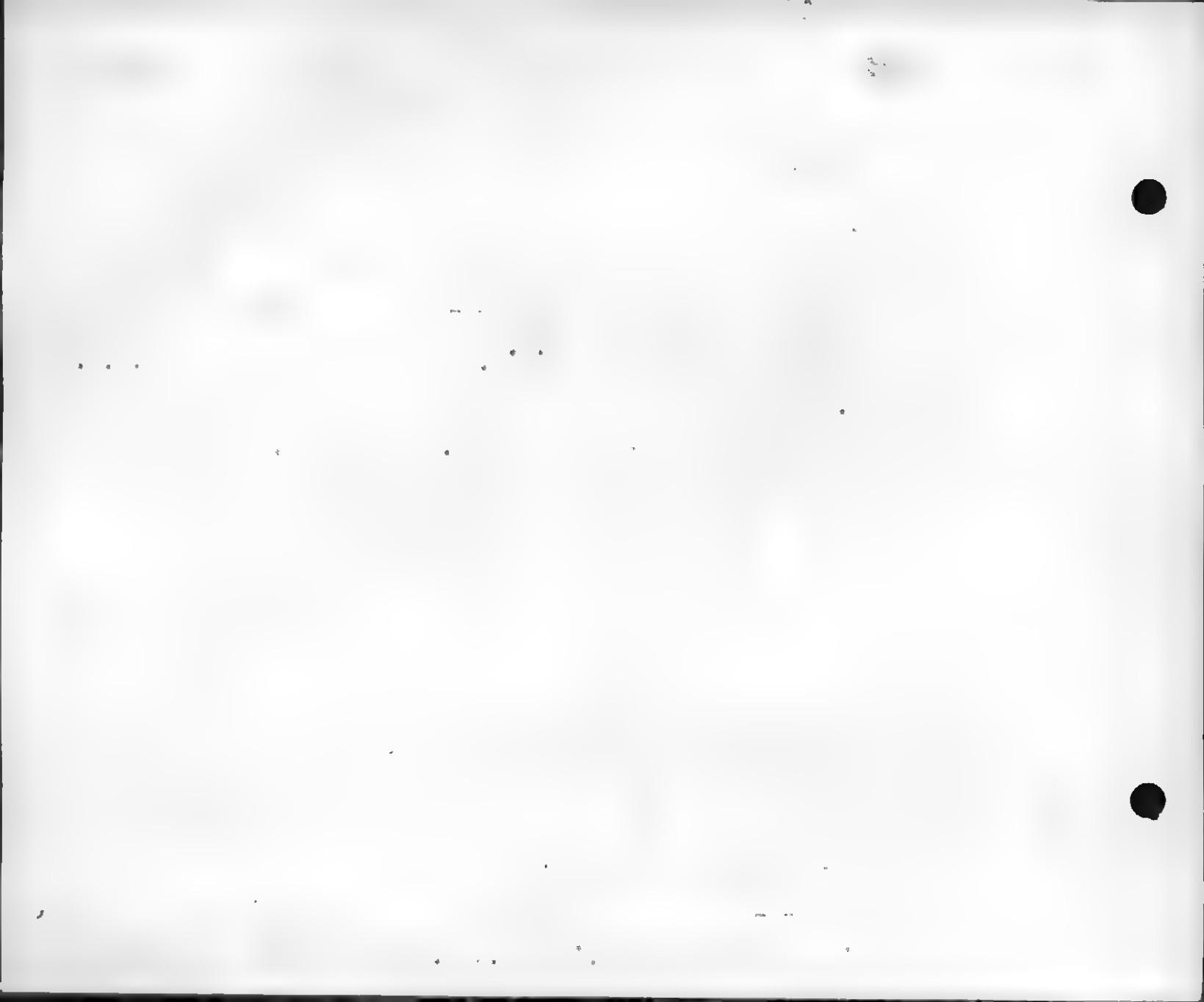
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06272

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DC262

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived if institution before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN TB Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1007 Reister Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First MAX	Middle R.	Last FULLERTON
4 DATE OF DEATH	Month May	Doy 4	Year 1967
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-8-1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bureau Chief		10b. KIND OF BUSINESS OR INDUSTRY News Papers Ret.	11 BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME George S. Fullerton		14. MOTHER'S MAIDEN NAME Annie Robe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECUR. NO. 233-10-6544	17. INFORMANT Mrs. Virginia R. Fullerton
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 834.4 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) DUE TO (c) DUE TO		Address Same	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20c. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Fell while getting out of car at home	
20c. TIME OF INJURY Month, Day, Year Hour pm 11:40 pm 5 - 3 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm factory, street, office bldg., etc.) curb - at home
20f. (City or town) Baltimore		(County) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5-8-1967	23c. NAME OF CEMETERY OR CREMATORIUM Greenmount
23d. LOCATION (City or Town) Baltimore,		(County) Md.	
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.		ADDRESS 21212 4905 York Rd. Balto., Md.	25a. REC'D BY REGISTRAR MAY 10 1967
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be filed as burial-transit paper. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

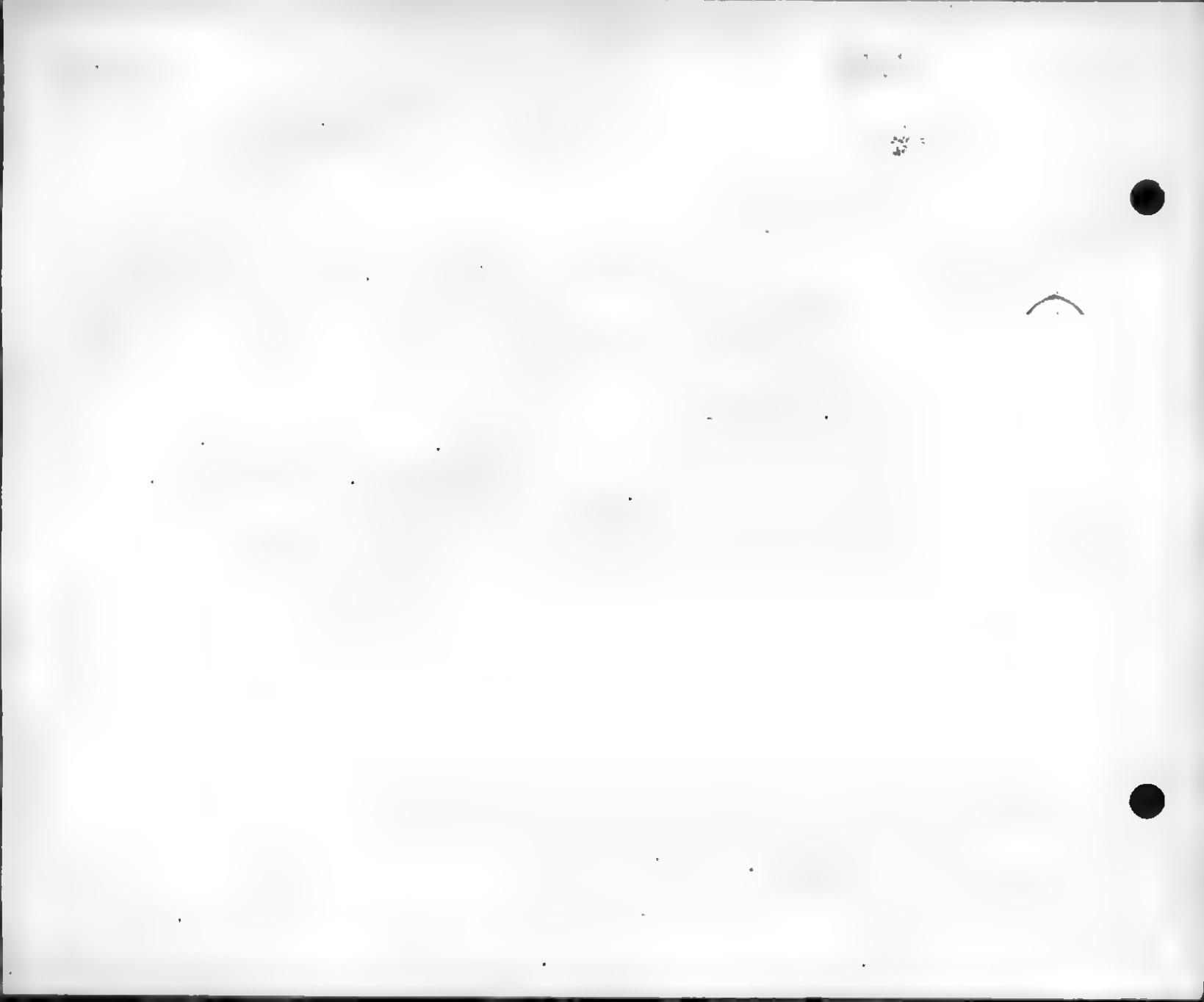
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06273

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06263

1 PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1544 Rolling Rd. 21227		d. STREET ADDRESS 1544 South Rolling Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF Harry Gorsuch (Type or print)		First Harry	Middle Gorsuch	Last Gallagher, Sr.	4 DATE OF DEATH May 26 1967	Month May	Day 26	Year 1967			
S SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/>	B DATE OF BIRTH 4/21/83	9 AGE (in years at birthday) 85 44 yrs	IF UNDER 1 YEAR Months 85	F UNDER 24 HRS Days 44	Hours 00	Min 00		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Retired		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Charles M. Gallagher		14. MOTHER'S MAIDEN NAME Anna Handly									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Harry G. Gallagher, Jr. Address 973 River Blvd., Suffield, Conn.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Carcinoma - Colon		DUE TO		INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c)		DUE TO									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASCDV		DUE TO									
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) Baltimore, Md.		(County) Md.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>James N. Frederick, M.D.</i>		EXAMINER'S NAME (Type) James N. Frederick, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5/26/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/29/67		23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		(County) Md.		(State) Md.	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE. 21229		ADDRESS		25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

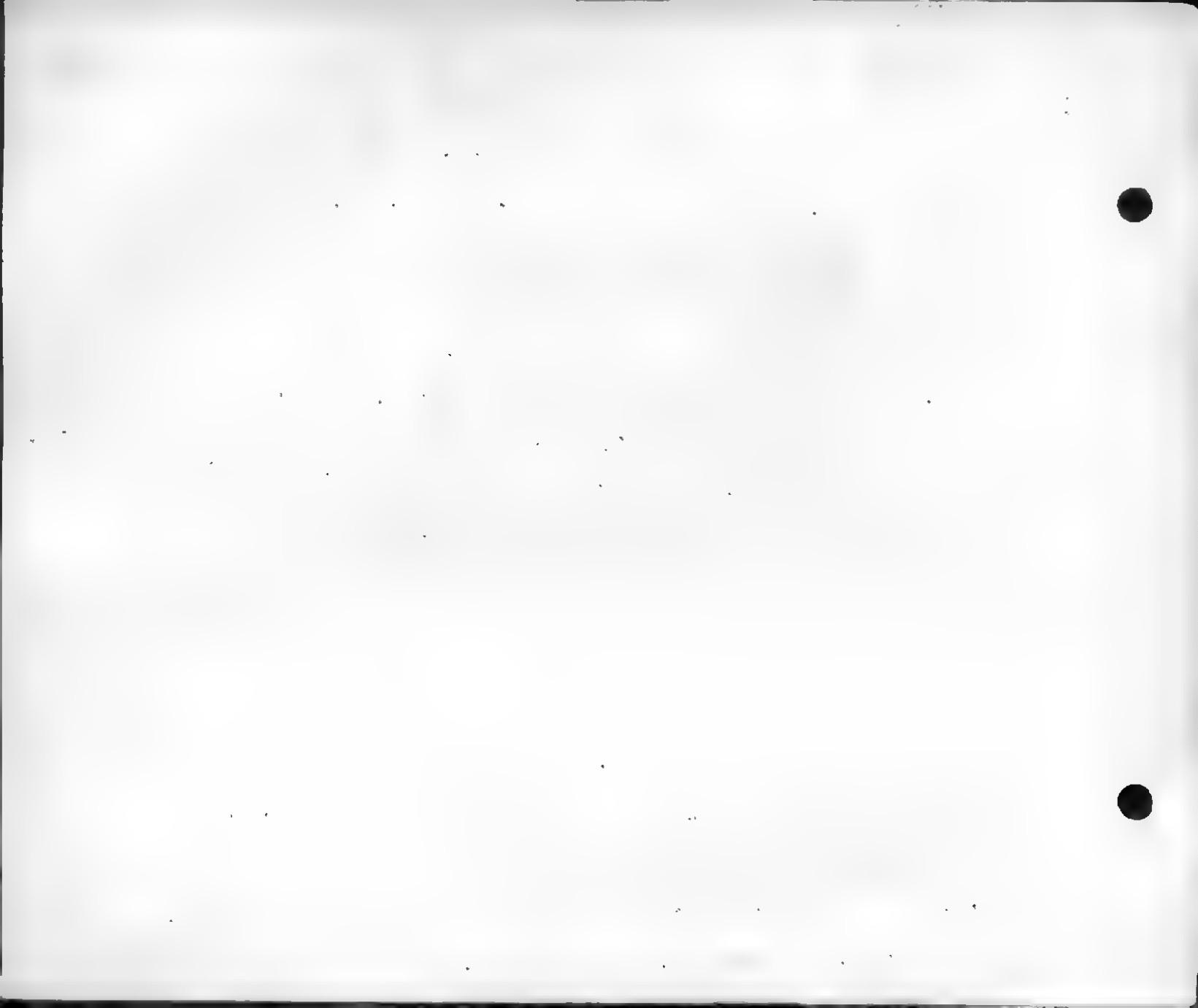
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 6264

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b Eight Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box-409 B. Rt. 16		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harewood, Chase Maryland	
3. NAME OF DECEASED (Type or print) Olive		First Beatrice	Middle Garrett
4. DATE OF DEATH May	Month 9	Day 19	Year 67
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 22, 1892
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 21043	
11. IF UNDER 24 HRS Days 8 MOS.		12. IF UNDER 24 HRS Hours 1 YR.	
10a. JOURNAL OF WORK DONE (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Penn.	
13. FATHER'S NAME J. Nelson Palmer		14. MOTHER'S MAIDEN NAME Mary O. Wilhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 213-42-3807A	INFORMANT Mr. Charles R. Garrett
		Address 29 Carlenda Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HISTASTATIC INTEGRASO. CARCINOMA ASCITES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INOPERABLE CARCINOMA OVARY DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/20 , 19 66 , to 5/9 , 19 67 , that I last saw the deceased alive on 5/8 , 19 67 , and that death occurred at 4:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 3350 Wilkins Avenue ACTUAL SIGNATURE <i>Robert Healy</i> DATE SIGNED 5/10/67			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/10/67	22c. NAME OF CEMETERY OR CREMATORIUM New Freedom Cemetery
22d. LOCATION (City, town, or county) New Freedom Pa.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Sander & Sons Inc. Baltimore Md.		24a. RECEIVED BY REGISTRAR DATE MAY 12 1967	24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06275

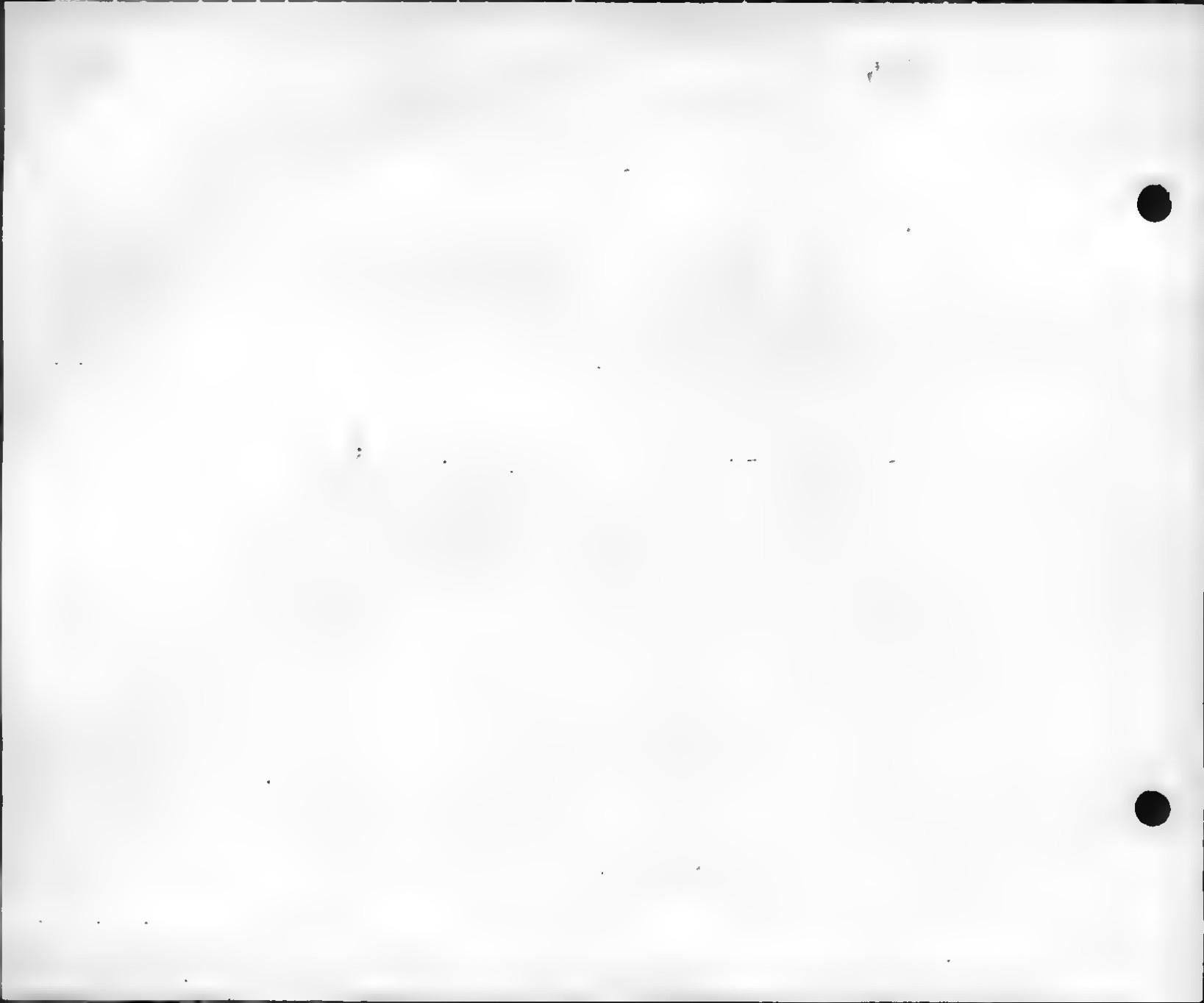
CERTIFICATE OF DEATH

10265

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY Baltimore			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 1 day		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital			d. STREET ADDRESS Putty Hill Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROBERT	First CORNELIUS	Middle GAY	4. DATE OF DEATH May 20 1967	Month May	Day 20
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	8. NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 22 1905	9. AGE (In years last birthday) 61 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Technician	10b. KIND OF BUSINESS OR INDUSTRY T.V.	11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME William Henry Gay			14. MOTHER'S MAIDEN NAME Nellie Dutrow		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO 217-09-8492		
17. INFORMANT Marie E. Gay, S Warren Lodge Ct. 21030			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pancreatitis.			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. b.					
DUE TO c.					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchiectasis, right lung.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from May 20, 1967 to May 20, 1967 , that (X) (we) last saw the deceased alive on May 20, 1967 , and that death occurred at 5:25 P.M. from causes and on the date stated above.					
22a. SIGNATURE <i>cockburn</i>			M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Manuel S. Cockburn, M.D.			22b. DATE SIGNED 5/21/67		
22d. ADDRESS 7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 24, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Parkville, Balto. Co., Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204			ADDRESS	25a. RECEIVED BY REGISTRAR MAY 23 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

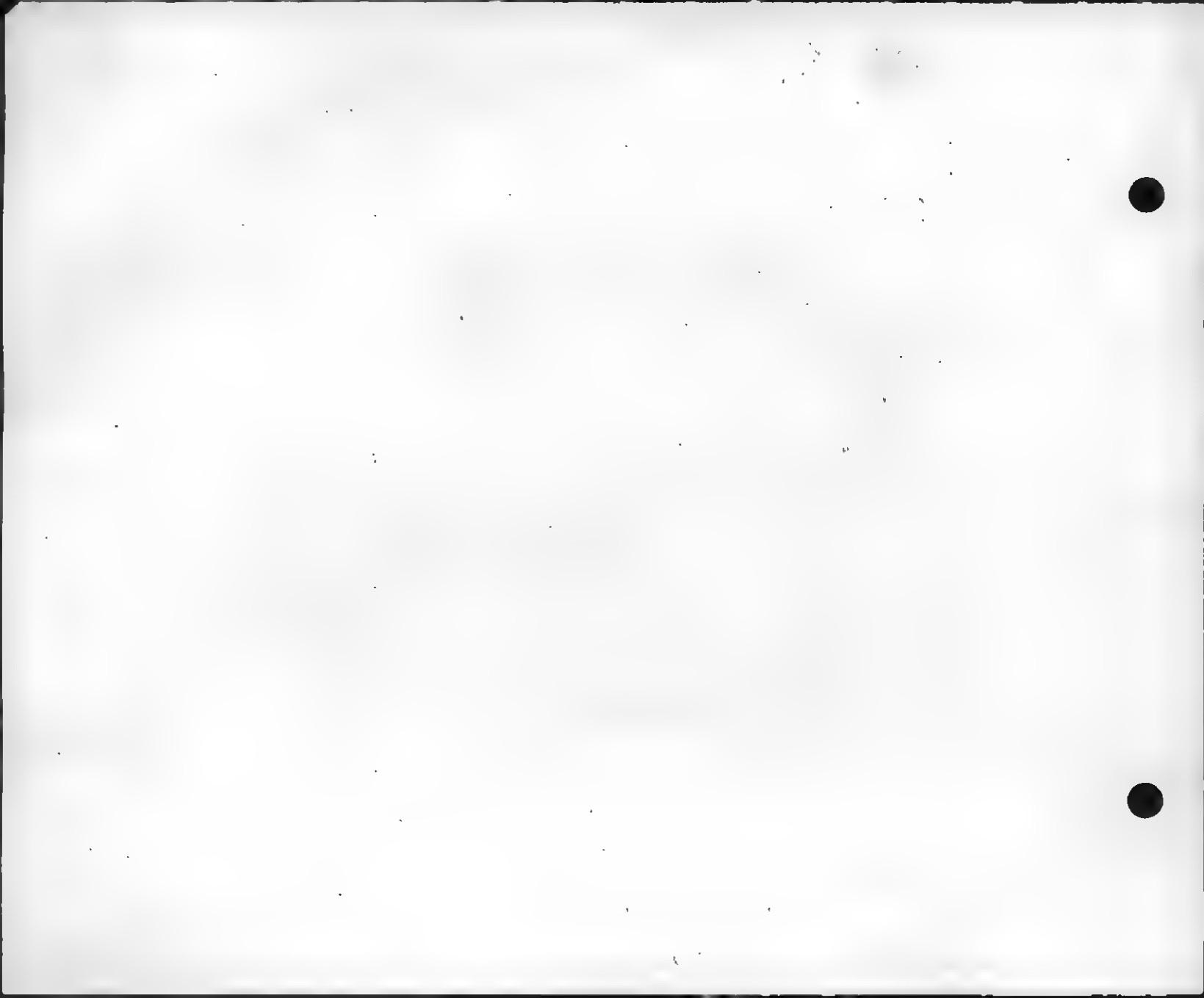


7 14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH					36276 36276				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u></u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>29 Normal Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Eva</u>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1895</u>	9. AGE (In years last birthday) <u>71 yrs.</u>	10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Aven J. Donovan</u>			14. MOTHER'S MAIDEN NAME <u>Mary L. Miller</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family records</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>BILATERAL PLEURAL EFFUSION</u> (c) <u>CARCINOMATOSIS (Adenocarcinoma of breast)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> 1 YEAR <u>10 YEARS</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that (I) (the deceased attended the deceased from <u>AUG 28, 1962</u> to <u>MAY 5, 1967</u> that (I) <u>last</u> saw the deceased alive on <u>MAY 5, 1967</u> , and that death occurred at <u>HOSPITAL</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Donald L. Somerville</u> M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>5/7/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>DONALD L. SOMERVILLE, MD</u>		22d. ADDRESS <u>25. W.P.A. AVE. TOWSON, MD 21204</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> DATE THEREOF <u>May 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Nt. Maria Cemetery</u>			23d. LOCATION (City, town or county) <u>Towson, Maryland</u> (State) <u></u>				
24. FUNERAL DIRECTOR ADDRESS <u>John Burns' Sons, Towson, Maryland</u>					25a. REC'D BY REGISTRAR <u>MAY 10 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #G3846567 pg 5

CERTIFICATE OF DEATH

JCS267

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home			d. STREET ADDRESS 1918 East 31st. Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Anita	Middle W.	Last Gibson	4. DATE OF DEATH 5 26 1967	Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/82	9. AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. SOIAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Deal Island, Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Lazarus Wilson			14. MOTHER'S MAIDEN NAME Annie Price					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)			16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Laiverence Adams		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. arteriesclerosis DUE TO (b) (c)	19. INTERVAL BETWEEN ONSET AND DEATH 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9/5 1965		20f. (City or town) 5/26 1967	(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/23 1967 , to 5/26 1967 that (we) last saw the deceased alive on 5/23 1967 , and that death occurred at 10:30 AM , from causes and on the date stated above.							22b. DATE SIGNED 5/27/67	
22c. SIGNATURE William F. Fritz		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) WILLIAM F. FRITZ, M.D.		22d. ADDRESS 2 WEST UNIVERSITY PKWY, 21218						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/29/1967		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		
24. FUNERAL DIRECTOR Wm. F. Fritz sons mortg Co.		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR DAT MAY 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

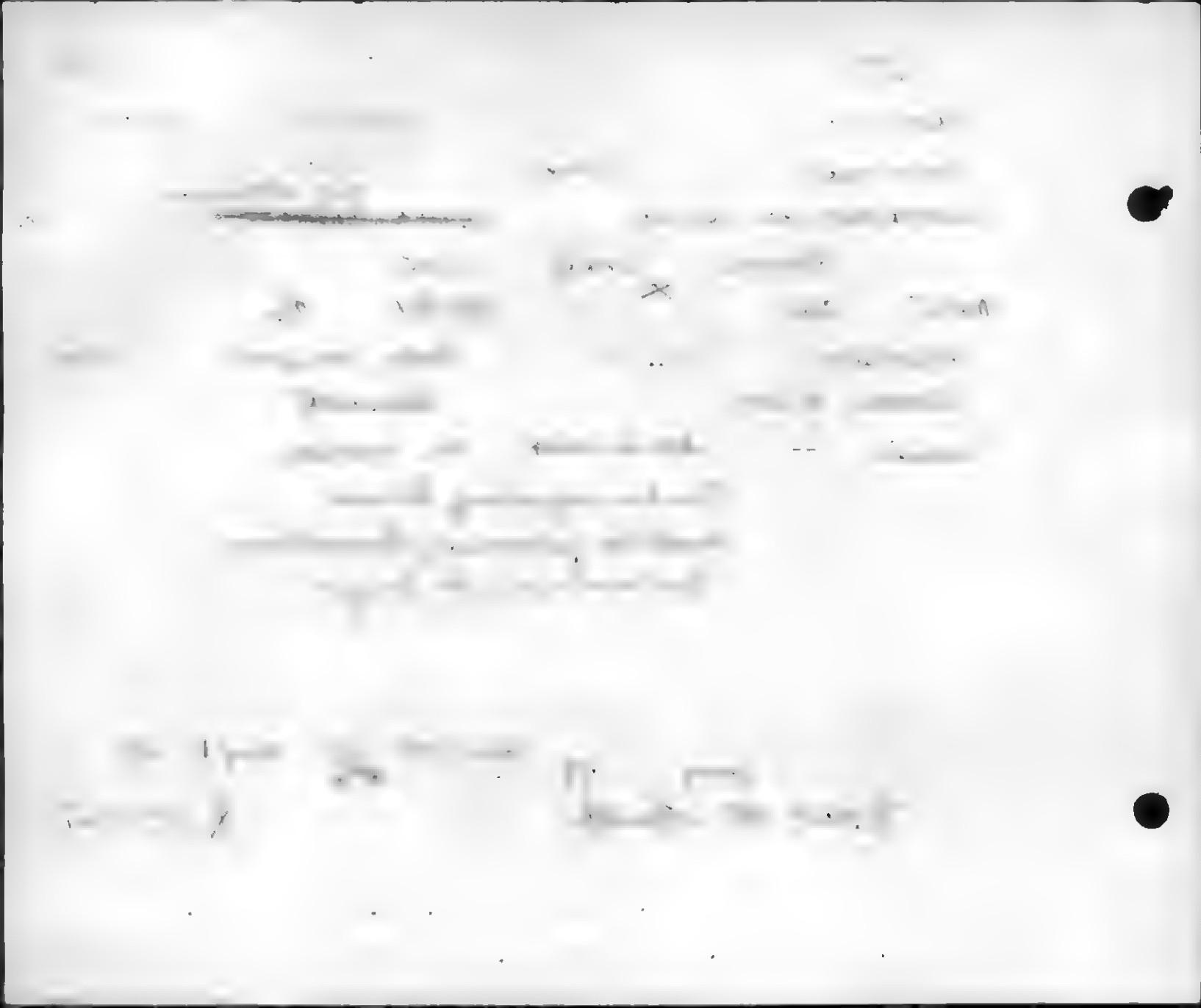
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

36278

CERTIFICATE OF DEATH

6636

1. PLACE OF DEATH COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 18 Days		a. STATE MARYLAND	b. COUNTY BALTO.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO MED. CENTER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne	
3. NAME OF DECEASED (Type or print)	First SAMUEL	Middle CARL	Last GILES	4. DATE OF DEATH 5 / 1 1967	Month Day Year
5. SEX MALE	6. COLOR OR RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 9/17/90	9. AGE (in years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Builder		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME GEORGE GILES		14. MOTHER'S MAIDEN NAME SHOCKER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-2304A		17. INFORMANT Pw. History	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) massive pulmonary hemorrhage					
DUE TO (c) Carcinoma of lung					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 14, 1967 to May 1, 1967 that (I) (we) last saw the deceased alive on May 1, 1967 and that death occurred at 2:45 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 5-1-67			
22a. SIGNATURE Robert W. Smith		22d. ADDRESS			
22c. PHYSICIAN'S NAME (Type)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/67		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk.	
24. FUNERAL DIRECTOR		ADDRESS JOHN F. DENNY, Inc. 715 Light St.		23d. LOCATION (City, town or county) (State) Dorsey, Md.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE MAY 3 1967 Charles Judge	
VR A15 (4) 20M 1/65					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06273

CERTIFICATE OF DEATH

06269

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Baltimore Md. 21204		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS 8210 Pleasant Plains Rd. 21204			
3. NAME OF DECEASED (Type or print) CHARLES L GLODEK		4. DATE OF DEATH Month MAY	Month Doy 14 19 67
S SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	11. BIRTHPLACE (County & State, or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Valentine Gledek		14. MOTHER'S MAIDEN NAME Marcella Jakubowski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 212-10-2587	
17. INFORMANT Wife - Lillian - same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 593 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Chronic renal failure		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-4-1967 to 5-14-1967 , that (I) (we) last saw the deceased alive on 5-14-1967 , and that death occurred at 5:40 AM , from causes and on the date stated above			
22a. SIGNATURE <i>Efraim L. Reyes</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Efraim L. Reyes, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-17-67	23c. NAME OF CEMETERY OR CREMATORIAL Holy Rosary Cemetery
24. FUNERAL DIRECTOR Johnson Funeral Home.		ADDRESS 8521 Loch Raven Blvd Balto. Md.	25a. REC'D BY REGISTRAR MAY 18 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If "Cry delayed", please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

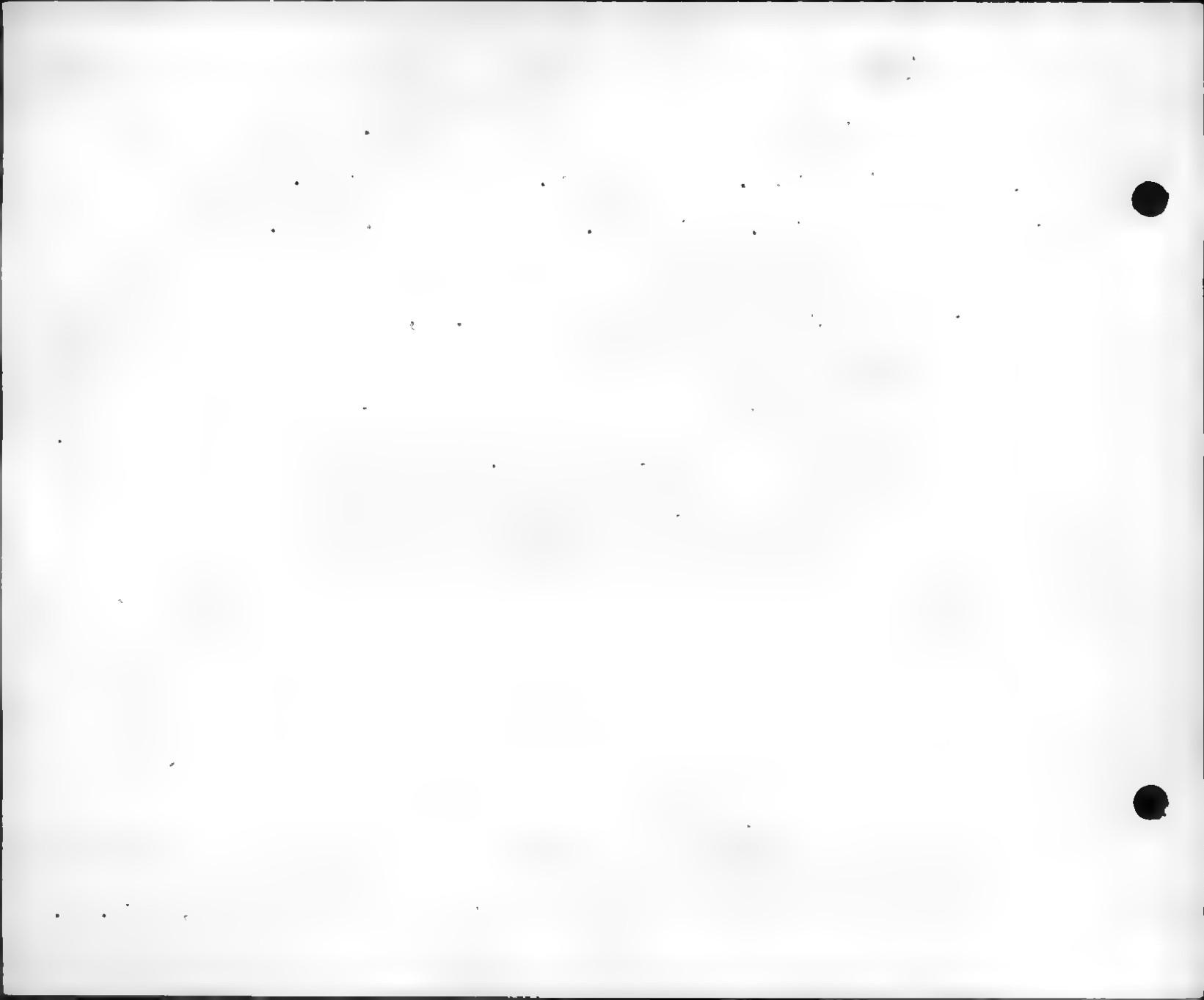
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36280

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06270

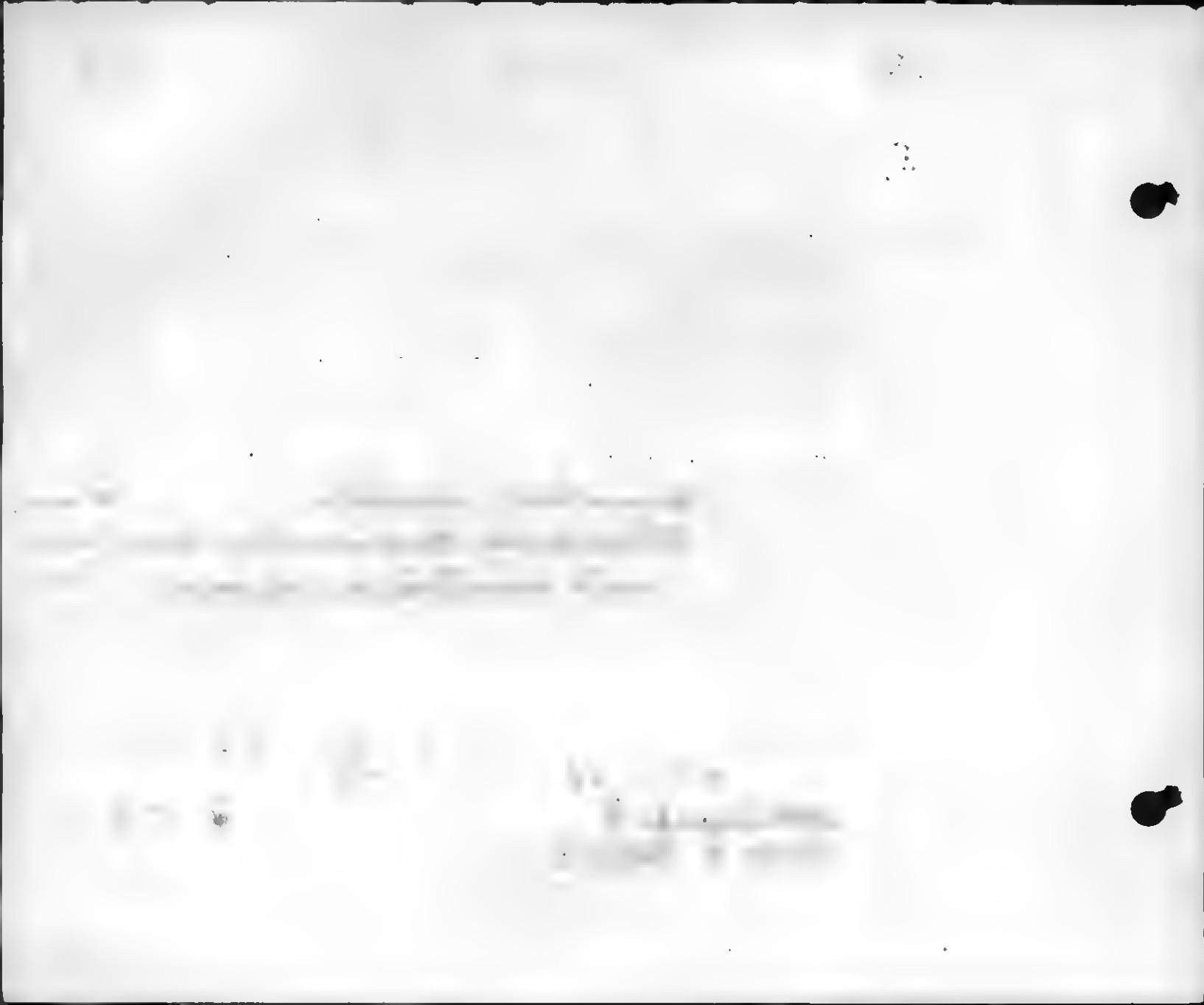
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 15, Md.</u>		c LENGTH OF STAY IN 1b <u>12 yrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4150 Fallstaff Rd., Baltimore, Md.</u>		e STREET ADDRESS <u>4150 Fallstaff Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Francesco</u>		First <u>Glorioso</u>	Middle <u>May 12,</u> Year <u>19 61</u>
S SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <u>Sept. 29, 1891</u>
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9 AGE (In years lost birthday) <u>15 yrs</u>
13 FATHER'S NAME <u>Rosario Glorioso</u>		11 BIRTHPLACE (State or foreign country) <u>Italy</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>212-36-0069</u>	17 INFORMANT <u>Mr. Joseph Glorioso, 117 Chestnut Hill Lane, Registerstown, Md.</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <u>none</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>none</u>	
20c TIME OF INJURY Month Day, Year Hour am pm <u>none 19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>none</u>	20e PLACE OF INJURY (Home, farm, factory, street, off ce bldg, etc.) <u>none</u>
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>5/15/67</u>	
ACTUAL SIGNATURE <u>D. D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <u>Druid Ridge Cemetery, Pikesville, Baltimore, Md.</u>	
23a BURIAL / CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>May 16, 1967</u>	23c NAME OF CEMETERY OR CREMATORIUM <u>Druid Ridge Cemetery</u>
24 FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville</u>		25d LOCATION (City or town) <u>Pikesville, Baltimore, Md.</u>	25e COUNTY (County) <u>Baltimore, Md.</u>
		ADDRESS <u>4150 Fallstaff Rd.</u>	25f REG'D BY REGISTRAR <u>SMAY 17 1967</u>
			25g REGISTRAR SIGNATURE <u>Charles J. Caples</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE												
Baltimore			MARYLAND												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1D												
Towson			5 Days												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. IS RESIDENCE ON A FARM?												
Greater Baltimore Medical Center			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
Helen			E.	Goeperfert		5	7	1967							
5. SEX			6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS.						
F			CAU	WIDOWED	DIVORCED	2-27-08	59 yrs.	Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
Housewife						Unknown Maryland			USA						
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT	Address		
JAMES Luszkiowski			GRODSKAF			No			Unknown			Patient's Chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			15 days												
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			DUE TO (b)	Myocardial infarction											
			DUE TO (c)	Atherosclerotic cardiovascular disease several years with coexisting anemic anemia											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
19															
21. I certify that (I) (this hospital) attended the deceased from 5-7, 1967, to 5-7, 1967, that (I) (we) last saw the deceased alive on 5-7, 1967, and that death occurred about 30 PM, from the causes and on the date stated above.															
22a. SIGNATURE Vivien R. Batoyon, M.D.			22b. DATE SIGNED 5-8-67												
22c. PHYSICIAN'S NAME (Type) VIVIEN R. BATOYON			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/11/67			23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer			23d. LOCATION (City, County, State) Baltimore, Maryland						
24. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE			ADDRESS			25a. REC'D BY REGISTRAR MAY 10 1967			25b. REGISTRAR'S SIGNATURE Charles Judge						
VR A15 (4) 20M 1/65															



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

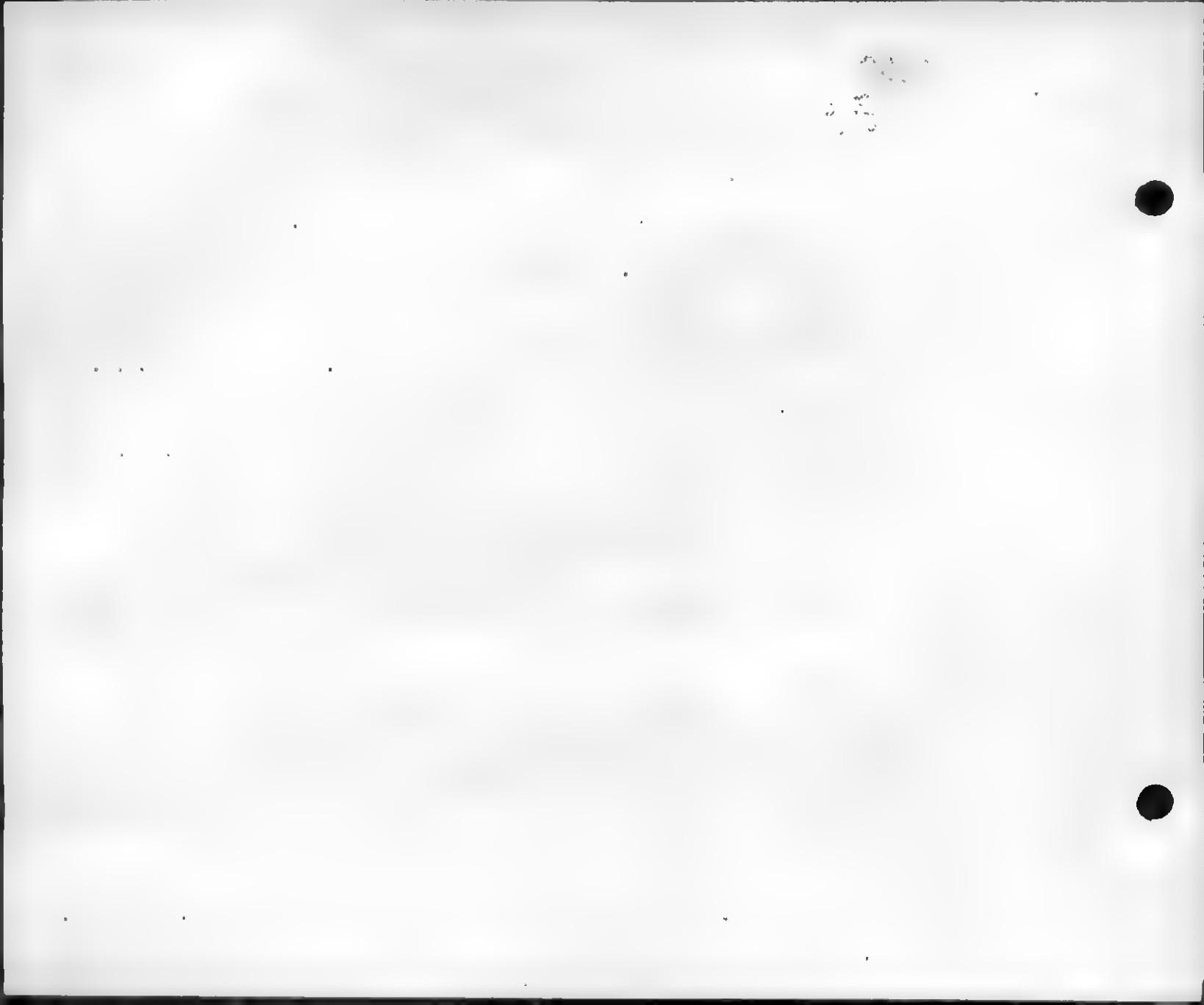
36282

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County, Md.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Baltimore, Md.</i>		b. COUNTY <i>Arundel</i>	
c. LENGTH OF STAY IN TB <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore County General Hospital</i>		d. STREET ADDRESS <i>60 Southgate Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Jeanette</i>	Middle <i>C.</i>	Last <i>Goodman</i>
4. DATE OF DEATH	Month <i>5</i>	Month <i>12</i>	Year <i>1967</i>
5. SEX	6. COLOR OR RACE <i>Female White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <i>4/6/87</i>	9. AGE (In years lost birthday) <i>80 yrs</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/>	11. IF UNDER 24 HRS Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Broker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Louis Isaacson I soc sohn</i>			
14. MOTHER'S MAIDEN NAME <i>Lillian Forman</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>213-34-2783</i>	17. INFORMANT Address <i>Miss Hilda Goodman Annapolis, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) - PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest failure 2°</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Ventricular fibrillation & fibrillation</i>			
DUE TO (c) <i>Severe arterial occlusive heart disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>			
4. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
5. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS DUE TO <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5-11</i> , 19 <i>67</i> , to <i>5-13</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5-13</i> , 19 <i>67</i> , and that death occurred at <i>772 M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Angela S. Toppan</i>		22b. DATE SIGNED <i>5-13-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>ANGELA S. TOPPAN</i>		22d. ADDRESS <i>Bedford</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 15, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Knesseth Israel</i>
23d. LOCATION (City or Town) (County) (State) <i>Annapolis, Md. Anne, Md.</i>		25a. DATE BY REGISTRAR <i>MAY 17 1967</i>	
24. FUNERAL DIRECTOR <i>Beverley E. Hopping, Hopping Funeral Home</i>		25b. REGISTRAR'S SIGNATURE <i>Beverley Hopping</i>	



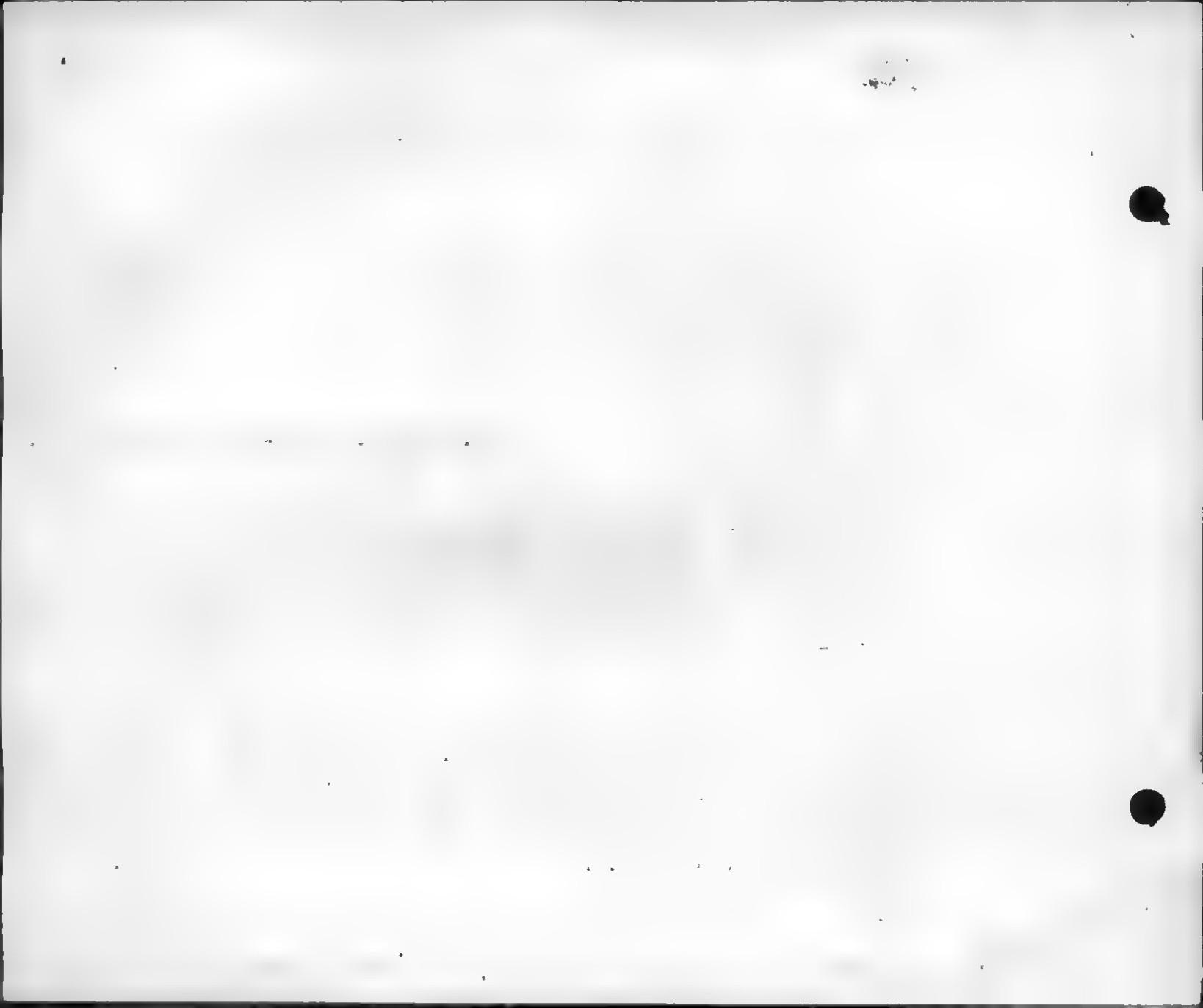
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36283

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard	c. LENGTH OF STAY IN TB 77 days	c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Baltimore 7	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 7117 Chamberlain Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First RALPH	Middle MICHAEL	Last GOONER
4. DATE OF DEATH Month May	Month 13	Day 19	Year 67
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 2/15/25
9. AGE (in years, last birthday) 42	10. KIND OF BUSINESS OR INDUSTRY Fleet Truck Motors	11. BIRTHPLACE (County & State, or foreign country) Milford, Dela.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Willis Gooner	14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI	16. SOCIAL SECURITY NO 221 12 47 78	17. INFORMANT Mrs. Ralph M. Gooner-7117 Chamberlain Rd., Clinical Rcds, VA Hospital, Fort Howard, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH Weeks 5 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) MULTIPLE ABSCESSSES, CHRONIC, LEFT PLEURAL CAVITY, lost LEFT LOWER THORACIC WALL, PELVIC CA VITY			Months Months
Underlying cause (c) METASTATIC ADENOCARCINOMA, LIVER AND MESENTERIC LYMPH NODES			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from Feb. 25, 1967 , to May 13, 1967 that (1) (we) last saw the deceased alive on May 13, 1967 , and that death occurred at 6 A. M. from causes and on the date stated above.			
22a. SIGNATURE Alfonso A. Lopez, M.D.		22b. DATE SIGNED 5/13/67	
22c. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/16/67	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR WITZKE FUNERAL HOME		25a. ADDRESS 1101 Edmondston Ave.	25b. REGISTRAR'S SIGNATURE Charles Judge
		25c. REC'D BY REGISTRAR MAY 16 1967	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

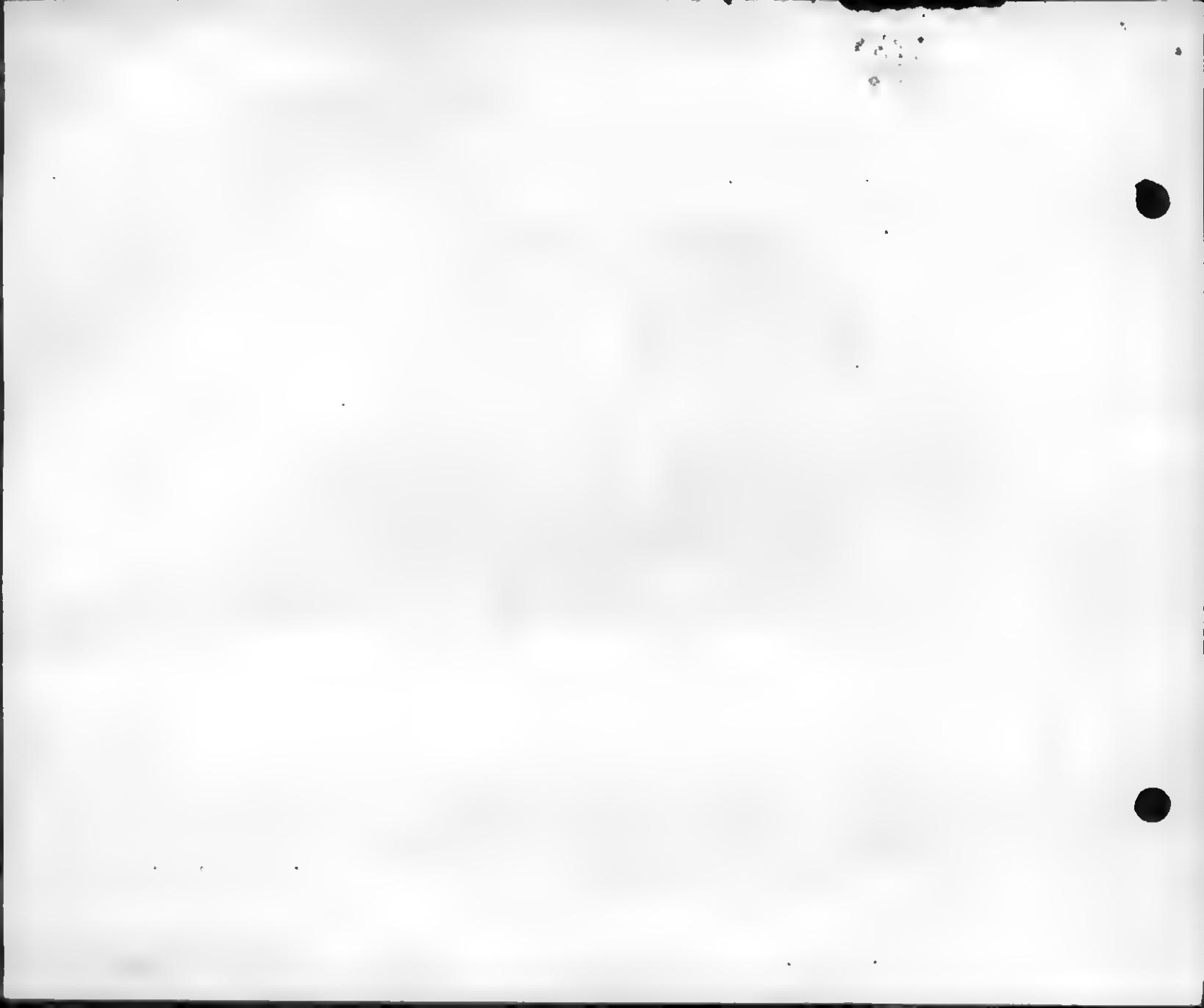
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers pages 1 and 2, directo, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36284

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Towson	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	d. STREET ADDRESS 2501 Hillford Drive		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edwin	Middle Rayne	4. DATE OF DEATH Month May Day 25 Year 1967		
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1894		
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Crown C+S			
11. BIRTHPLACE (Country & State, or foreign country) Penn		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Wm. Frederick Gowland	14. MOTHER'S MAIDEN NAME M. A. Feistil				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIA. SECURITY NO. 188-05-6364	17. INFORMANT Family Records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema secondary to anemic DUE TO Heart Disease. 2421 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to hypoplasia of bone marrow. (c) _____					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) York (County) Penn (State) Penn				
20. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19					
21. I certify that (I) (this hospital) attended the deceased from May 22 , 1967, to May 25 , 1967, that (I) (we) last saw the deceased alive on May 25 1967, and that death occurred at 1:30 P.M., from causes and on the date stated above					
22a. SIGNATURE Lawrence F. Misanik, M.D.	M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS 7620 York Rd. Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Reburial	23b. DATE THEREOF 5-26-1967	23c. NAME OF CEMETERY OR CREMATORIAL MARY'S Cem	23d. LOCATION (City or Town) York (County) Penn (State) Penn		
24. FUNERAL DIRECTOR C. F. Evans & Son	ADDRESS 8802 Hillford Rd	25a. REC'D BY REGISTRAR DATE MAY 29 1967	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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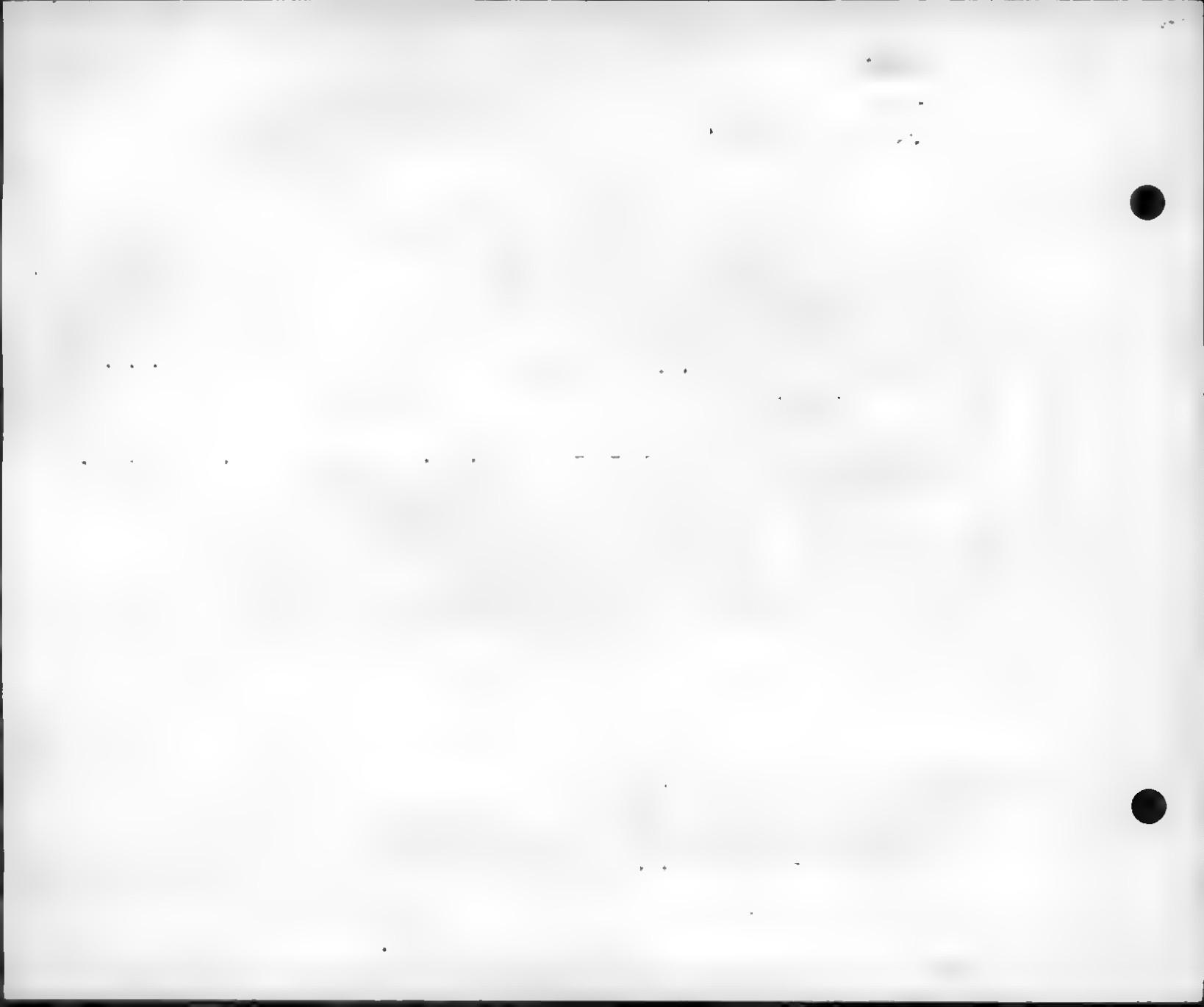
DC275

CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard	c. LENGTH OF STAY IN 1b 19 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 4409 Fernhill Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VICTOR VINCENT GRELLI	First VICTOR	Middle VINCENT	Last GRELLI
4. DATE OF DEATH MAY 27 1967	Month MAY	Doy 27	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/18
9. AGE (In years last birthday) 47 yrs	10. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard	11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Vincent Grelli		14. MOTHER'S MAIDEN NAME Philomenia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 213-14-82-04	
17. INFORMANT Clin. Rec. VA HOSPITAL, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR LEFT FRONTAL LOBE		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
23'X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, off ce bldg, etc) VA HOSPITAL, FORT HOWARD, MARYLAND
20f. (City or town) FORT HOWARD		(County) (State) MARYLAND	
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from May 8, 1967 to May 27, 1967 , that <input type="checkbox"/> (we) last saw the deceased alive on May 27, 1967 , and that death occurred at 7:00AM from causes and on the date stated above			
22. SIGNATURE Z-S-Tao		MD ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/27/67
22c. PHYSICIAN'S NAME (Type) ZUI-SUN TAO, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 5-31-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore National Cemetery 4600 Liberty Hghts Ave	23d. LOCATION (City or Town) Baltimore, Maryland
23e. FUNERAL DIRECTOR Ethelred Armacost		23f. REC'D BY REGISTRAR Charles Judge	23g. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 25M 1/67			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06286

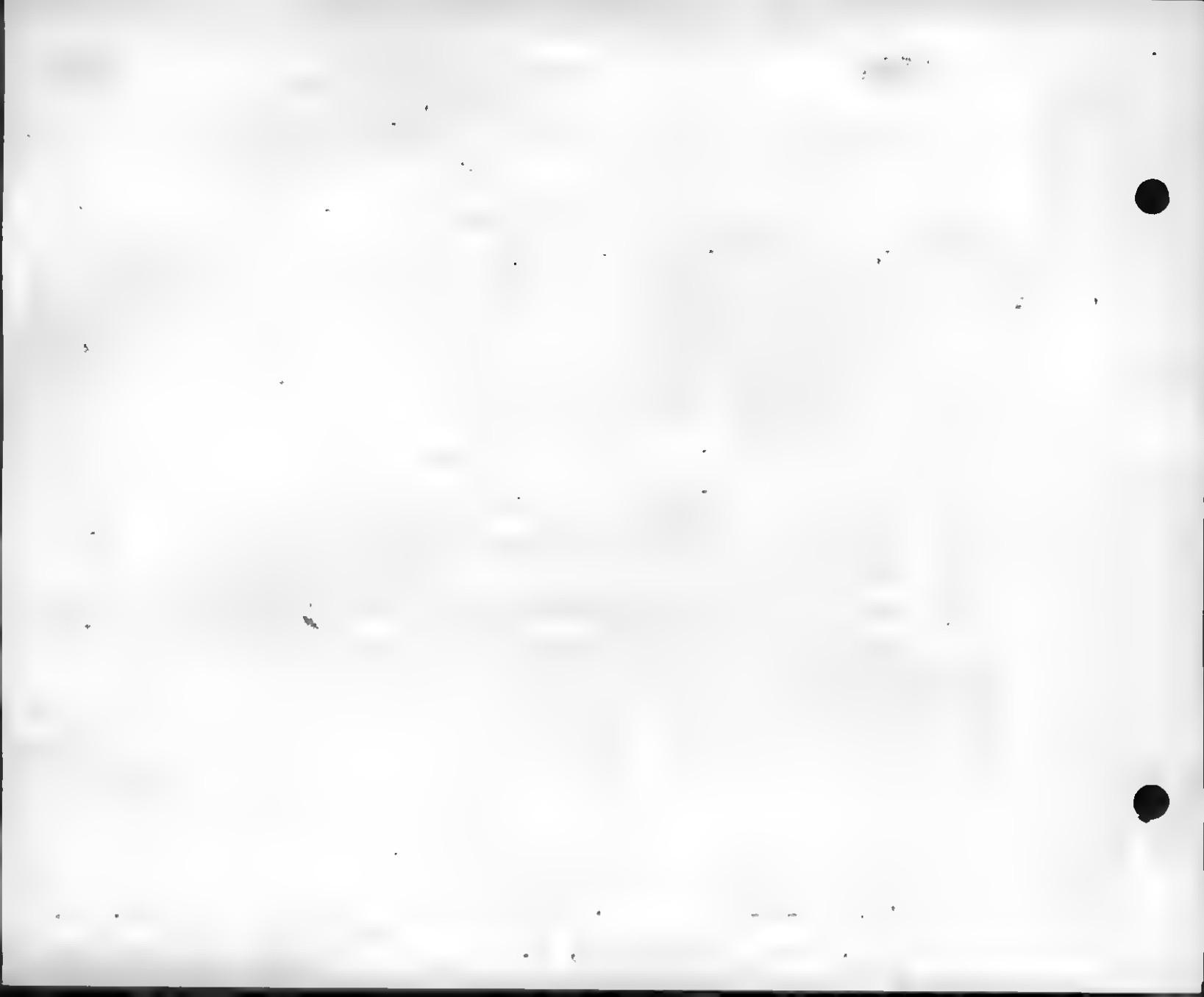
CERTIFICATE OF DEATH

05276

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore County		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
3 NAME OF DECEASED (Type or print) THOMAS CLIFTON GRIMES		4. DATE OF DEATH Month 5 Day 10 Year 1967	
S SEX M	6 COLOR OR RACE W	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 NEVER MARRIED DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b KIND OF BUSINESS OR INDUSTRY Farm	
13 FATHER'S NAME WILLIAM GRIMES		11 BIRTHPLACE (County & State, or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0479	
17. INFORMANT Records, Mount Wilson State Hospital		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic heart disease (b) Arteriosclerotic heart disease DUE TO (c)	
20a. MEDICAL CERTIFICATION ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 7 days	
20b. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20c. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Chronic obstructive airway disease (Emphysema)	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) Frederick (County) Maryland (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-12 , 19 67 , to 5-10 , 19 67 , that (I) (we) last saw the deceased alive on 5-12 , 19 67 , and that death occurred at 5:40 A.M. , from causes and on the date stated above.		22b. DATE SIGNED 5.10.1967	
22c. SIGNATURE Newcomer		22d. ADDRESS Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REBURIAL (Specify) Burial		23b. DATE THEREOF 5-13-67	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet		23d. LOCATION (City or Town) (County) (State) Frederick, Fred. Md.	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REG'D BY REGISTRAR MAY 12 1967	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96287

CERTIFICATE OF DEATH

06277

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland #21231		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Life		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St Joseph Hospital			e. STREET ADDRESS 1807 Aliceanna St.		

3. NAME OF DECEASED (Type or print)	First Constance	Middle A.	Last Gruszczynski	4 DATE OF DEATH Month 5	Day 16	Year 1967
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1897	9. AGE (In years at birthday) 70 yrs	F UNDER 1 YEAR Months 0	F UNDER 24 HRS Hours 0	Min 0
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10. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME Lawrence Milanicz	14. MOTHER'S MAIDEN NAME Agnes Glinski	Address #21231
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 220-01-0821	17. INFORMANT Gilbert Gruszczynski - 1807 Aliceanna St.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism	INTERVAL BETWEEN ONSET AND DEATH
170 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bedridden, Peripheric Edema	
(c)	

MEDICAL CERTIFICATION	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Radical Rt. Mastectomy for Ca. of the Breast			19. WAS AUTOPSY PERFORMED? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>)
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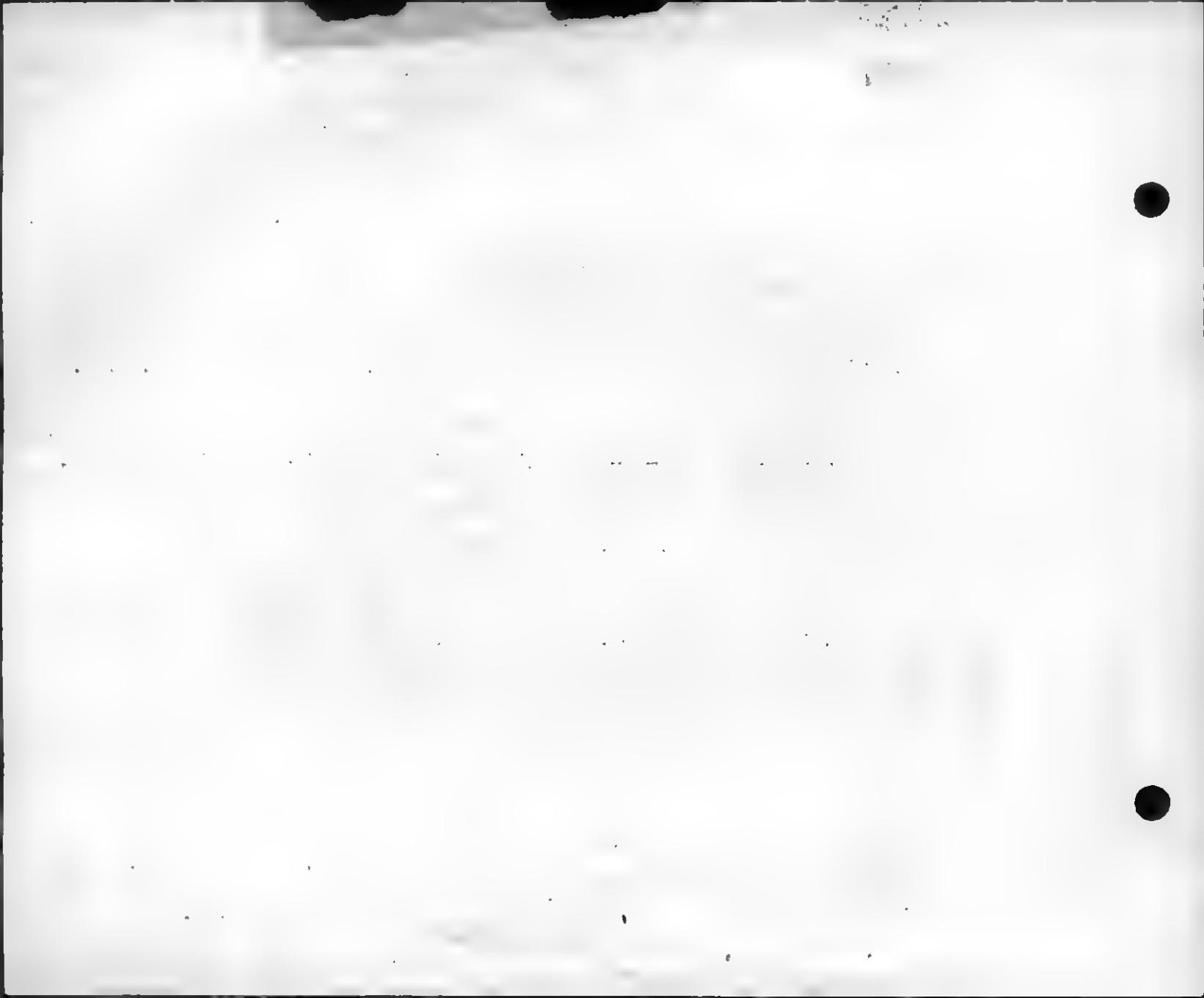
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that (I) (this hospital) attended the deceased from 4/26 , 1967, to 5/16 , 1967, that (I) (we) last saw the deceased alive on 5/16 , 1967, and that death occurred at 6:15 p.m. from causes and on the date stated above	22b. DATE SIGNED 5-16-67
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22a. SIGNATURE Roberto Ferrer	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 5-16-67
22c. PHYSICIAN'S NAME (Type) Roberto O. Ferrer	22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/20/67	23c. NAME OF CEMETERY OR CREMATORIUM St. Stanislaus Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
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24. FUNERAL DIRECTOR George A. Weber 705 S. Ann Street	ADDRESS George A. Weber	25a. REC'D. BY REGISTRAR MAY 18 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06288		06278	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN lb 6 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Greater Baltimore Medical Center 3626 Lochearn Dr e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Aloysius Guyer First John Middle Aloysius Last Guyer 4. DATE OF DEATH 5 29 1967			
5. SEX Male	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/86
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Retired		9. AGE (In years last birthday) 80 yrs.	
11b. KIND OF BUSINESS OR INDUSTRY Roadside Doctor		11c. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Penna.	
13. FATHER'S NAME John Guyer		14. MOTHER'S MAIDEN NAME Mary Bohannan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 213-10-2601	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) CONGESTIVE HEART FAILURE DUE TO (c) MYOCARDIAL INFARCTION DUE TO Last.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHOPNEUMONIA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Towson
20f. (City or town) Towson		(County) BALTO. CO. (State) M.D.	
21. I certify that (I) (this hospital) attended the deceased from 5/24 1967 to 5/29 1967 , that (I) (we) last saw the deceased alive on May 29 1967 , and that death occurred at 2:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Evelyn L. Ramos, M.D.		22b. DATE SIGNED 5/29/67	
22c. PHYSICIAN'S NAME (Type) EVELYN L. RAMOS, M.D.		22d. ADDRESS G.B.M.C., Towson 4	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORIAL Druide Ridge Cem
23d. LOCATION (City or Town) BALTO. CO. M.D.		(County) BALTO. CO. (State) M.D.	
24. FUNERAL DIRECTOR Burgess Funeral Home 3634 Falls Rd		25a. ADDRESS Lynn Burgess	25b. REC'D BY REGISTRAR JUN 2 1967
		25c. REGISTRAR'S SIGNATURE JUN 2 1967	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. S may be retained for your files.

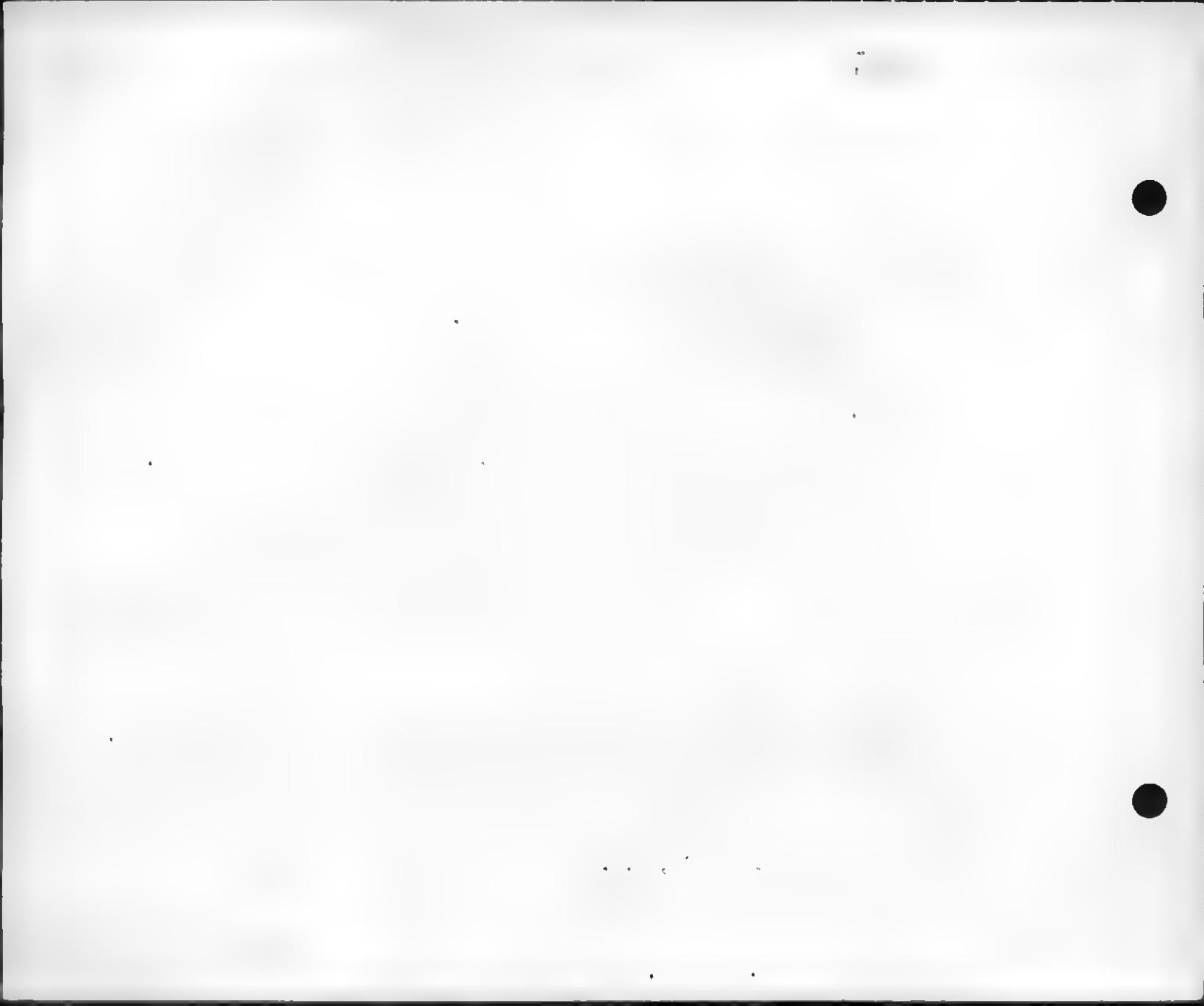
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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06283

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 818 Fairway Drive		d. STREET ADDRESS 818 Fairway Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CHARLES MATHIAS HAHN		First MIDDLE Last	4 DATE OF DEATH Pronounced 5 Doy Year 3 1967
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 12, '35 9 AGE (In years lost birthday) 31 yrs F UNDER 1 YEAR Months Days Hours Min
10 DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11 BIRTHPLACE (State or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob H. Hahn		14 MOTHER'S MAIDEN NAME Hilda Beutzen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	17. INFORMANT Mrs. Lillian J. Rosenberg, 14 W. Cold Address Spring Lane
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) stating the underlying cause (c) lost DUE TO lost (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Shot self in head	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. Unknown		20d. INJURY OCCURRED Where at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off a bldg, etc.) Home 20f. (City or town) Towson 20g. (County) Balto. 20h. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county) RUSSELL S. FISHER, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 6, 1967 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS New Cathedral Cemetery Baltimore, Maryland	
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.		25a. REG'D BY REGISTRAR MAY 8 25b. REGISTRAR'S SIGNATURE Charles Judge	DATE 1967



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26280

FOR STATE
HEALTH PER

er death. If any delay is
ive Pages 1, 2, and 3 ta-
ing with form PM3 Page

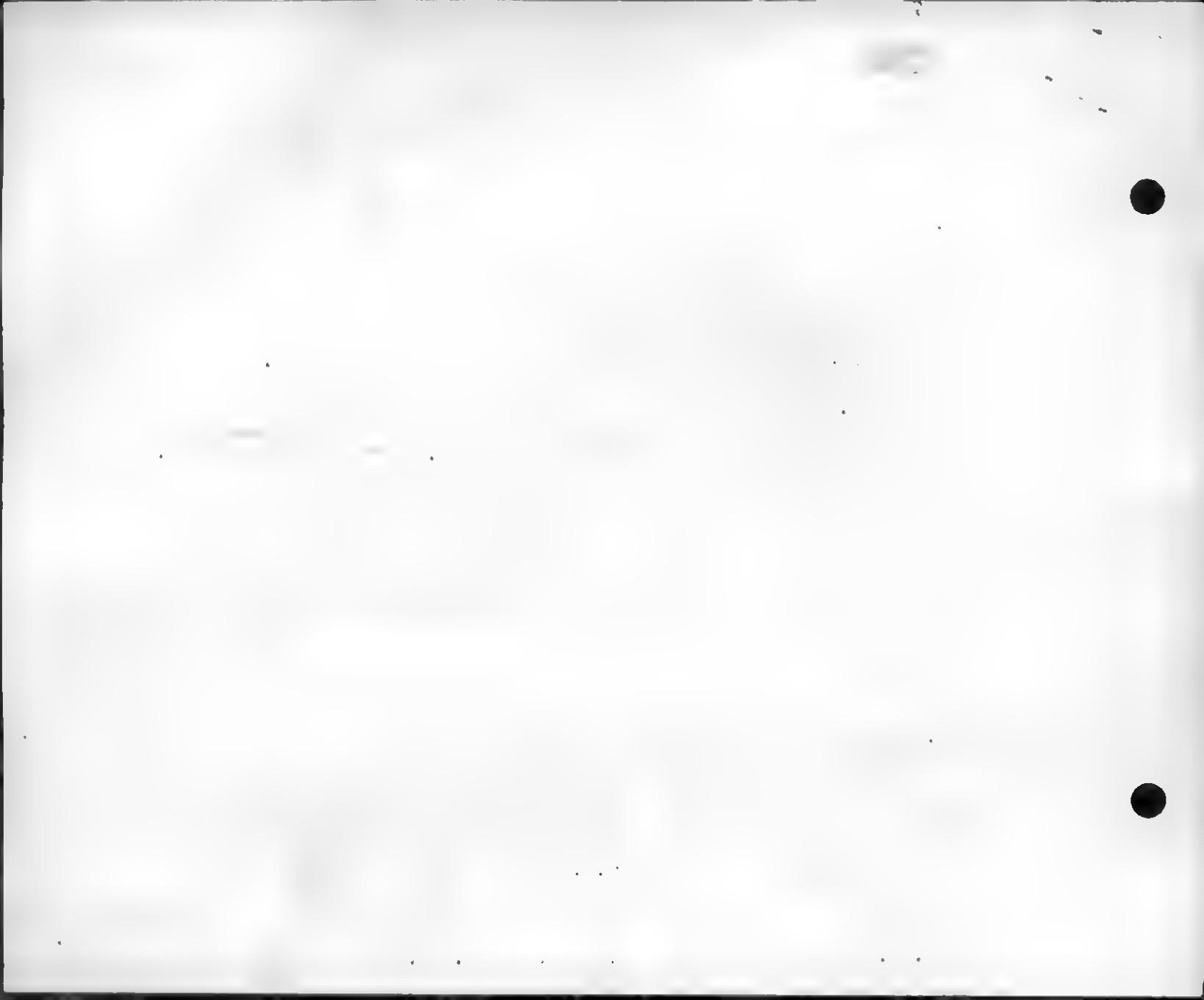
INRUL DIRCTR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

36290

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland									
c. LENGTH OF STAY IN LD Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital - DOA				d. STREET ADDRESS Muscatine		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
e. NAME OF DECEASED (Type or print)		First KENNETH	Middle FRANKLIN	Last HAHN	4. DATE OF DEATH 5	Month 28	Day Year 1967						
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 10-30-40		9. AGE (In years last birthday) 26 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min					
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if ret red) Trainee-Manager			10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY USA						
13. FATHER'S NAME Robert H. Hahn				14. MOTHER'S MAIDEN NAME Mary Jane Stine									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of serv (c) No			16. SOCIAL SECURITY NO. 213 36 8962		17. INFORMANT Sarah L. Hahn 1644 XXXXXXXX Rd. 21204								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) DUE TO (c)				Craniocerebral injuries									
				INTERVAL BETWEEN ONSET AND DEATH									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Driver of auto which ran off road at Long Green and Hannibal Roads						20c. TIME OF INJURY Month, Day Year Hour a.m. App. 12:21 AM 5-28 1967		20d. PLACE OF INJURY (Home, farm factory, street, office, bldg., etc.) Road	20e. (City or town) Baltimore	(County) Md.	(State)
21. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22. DATE SIGNED 5-28-67					
ACTUAL SIGNATURE 								CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county) RUSSELL S. FISHER, M.D.					
23a. BURIAL CREMATION, REMOVAL (See (f)) Burial		23b. DATE THEREOF 5-31-67		23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Memorial Gardens		23d. LOCATION (City or Town) Baltimore		(County) 6, Maryland		(State)			
24. FUNERAL DIRECTOR Wm. E. Johnson, 8521 Loch Raven Bl. Balt. Md.				ADDRESS JUN 5 1967		25a. RECD BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge					

VR A15ME (1)
6M 1/67

51



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

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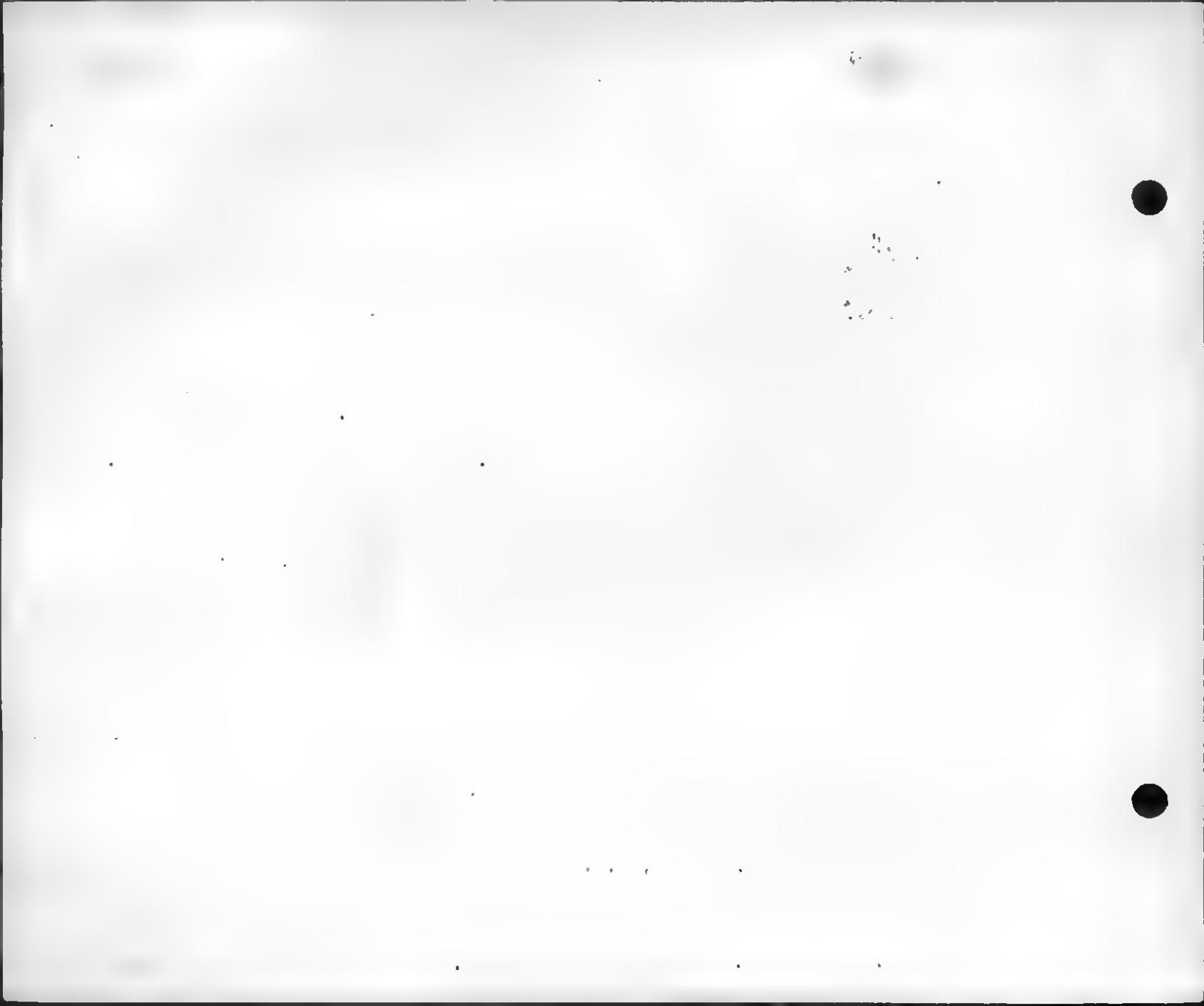
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

26291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DE281

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY N/A	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 818 Fairway Drive		e STREET ADDRESS 818 Fairway Drive	
f S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		g DATE OF DEATH Month Day Year 5 3 67	
3 SEX Female	4 FIRST MIDDLE MARY LOUISE	5 LAST HAHN	6 DATE OF BIRTH Mar. 26, 1935
7 MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 COLOR OR RACE White	9 AGE (in years last birthday) 32 yrs.	10 IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Leo A. Rosenberger		14 MOTHER'S MAIDEN NAME Lillian J. Jacobs	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16 SOCIAL SECURITY NO Unknown	
17 INFORMANT Mrs. Lillian J. Rosenberger 14 W. Cold		18 ADDRESS Spring Lane	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of head		20 INTERVAL BETWEEN ONSET AND DEATH	
19a DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause Unknown		21b DUE TO (b) Unknown	
21c DUE TO (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Presumably shot by husband	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. Unknown		20d INJRY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Unknown	20e PLACE OF INJRY (Home, farm, factory, street, office bldg., etc.) Home
20f (City or town) Towson		(County) Balto.	
		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		Address (Street, city, town or county) Baltimore, Maryland	
23a BURIAL, CREMATON, REMOVAL (Specify) Burial		23b DATE THEREOF 5/6/67	
23c NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery		23d LOCATION (City or Town) Baltimore, Maryland	
24 FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.		25e REG'D BY REGISTRAR DATE May 8 1967	
		25d REGISTRAR'S SIGNATURE 	





FOR STATE
HEALTH DEPT.

Necessary, please execute the cert. rate, writing the word "pending" in part I in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch. of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department at death prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36283

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 709 Kingston, Rd.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21212		
c. LENGTH OF STAY IN b. 5 yrs.			d. STREET ADDRESS 709 Kingston, Rd.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore,			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William E. Haverstick	Middle 	Last 	4. DATE OF DEATH Month May 21, Year 1967
S. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 1, 1887	9. AGE (In years 79 birthday) yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Baker			10b. KIND OF BUSINESS OR INDUSTRY Baking	11. BIRTHPLACE (State or foreign country) Adams Co. Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Addison			14. MOTHER'S MAIDEN NAME Haverstick		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 213-30-6650	17. INFORMANT Josephine Haverstick, 709 Kingston Rd.	Address
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Dystrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Disease			INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. MEDICAL CERTIFICATION					
20a. EXTERNA CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. CITY OR TOWN (County) Cockeysville, Md.	(State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Cockeysville, Md.			
23a. BURIAL/CREMATION, REGISTRATION (if applicable) Burial		23b. DATE THEREOF May 24, 67	23c. NAME OF CEMETERY OR CREMATORIUM Dulaney Valley	23d. LOCATION (City or Town) (County) Cockeysville, Md.	(State) MD
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Md.		ADDRESS	25a. REC'D. BY REGISTRAR MAY 26 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

06294

CERTIFICATE OF DEATH

06294

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		b. COUNTY BALTIMORE	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1648 FOREST PARK AVENUE		d. STREET ADDRESS 1648 FOREST PARK AVENUE	
3. NAME OF DECEASED (Type or print)	First ROSA E. HAYNIE	Middle Midd a	4. DATE OF DEATH 5/19/67
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH 1/30/83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHARLES WALKER		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 17. INFORMANT FAMILY - SALE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 18 ms	
DUE TO		CARCINOMA - RECTUM & GENERALIZED CARCINOMATOSIS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 6/15 , 19 66 , to 5/19 , 19 67 , that (I) (we) last saw the deceased alive on 5/18 , 19 67 , and that death occurred at 3 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE <i>Norman R Kleiman</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/20/67
22c. PHYSICIAN'S NAME (Type) NORMAN R. KLEIMAN		M.D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) B		23b. DATE THEREOF 5/22/67	23c. NAME OF CEMETERY OR CREMATORIAL MEADOW RIDGE
24. FUNERAL DIRECTOR'S SIGNATURE <i>K. Kelly - 237 Patapsco Ave.</i>		ADDRESS	23d. LOCATION (City, town or county) BALTIMORE



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06295

CERTIFICATE OF DEATH

06285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTO.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD.		b. COUNTY BALTO		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. LENGTH OF STAY IN lb 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. COUNTY GEN. HOSP.		d. STREET ADDRESS 6003 WINDSOR MILL RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
NAME OF DECEASED (Type or print) LULA		First L	Middle U	LAST HEARN	4. DATE OF DEATH 1/30/84	Month 1	Day 2	Year 1967
5. SEX F	6. COLOR OR RACE XL	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/84	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME PATRICK ALBION		14. MOTHER'S MAIDEN NAME ROSA BYRD		Address Edward D. Hearn 6003 Windsor Mill Rd.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) REFRACTORY CONGESTIVE HEART FAILURE		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ASCVD		DUE TO (b)		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH long time		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4/29/67, 19 to 5/2/67, 19 , that (I) (we) last saw the deceased alive on 5/2/67, 19 , and that death occurred at D/N/M , from causes and on the date stated above.								
22a. SIGNATURE Milton Schlenoff, M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-2-67
22c. PHYSICIAN'S NAME (Type) MILTON SCHLENOFF		22d. ADDRESS BALTO. COUNTY HOSP						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/67		23c. NAME OF CEMETERY OR CREMATORIAL Parsons		23d. LOCATION (City or Town) Salisbury		(County) Maryland
24. FUNERAL DIRECTOR J.I. SIANSBURG		ADDRESS 6417 Windsor Mill Rd.		25a. REC'D BY REGISTRAR MAY 4 1967		25b. REGISTRAR'S SIGNATURE Charles J. Charles J. Judge		

1
1



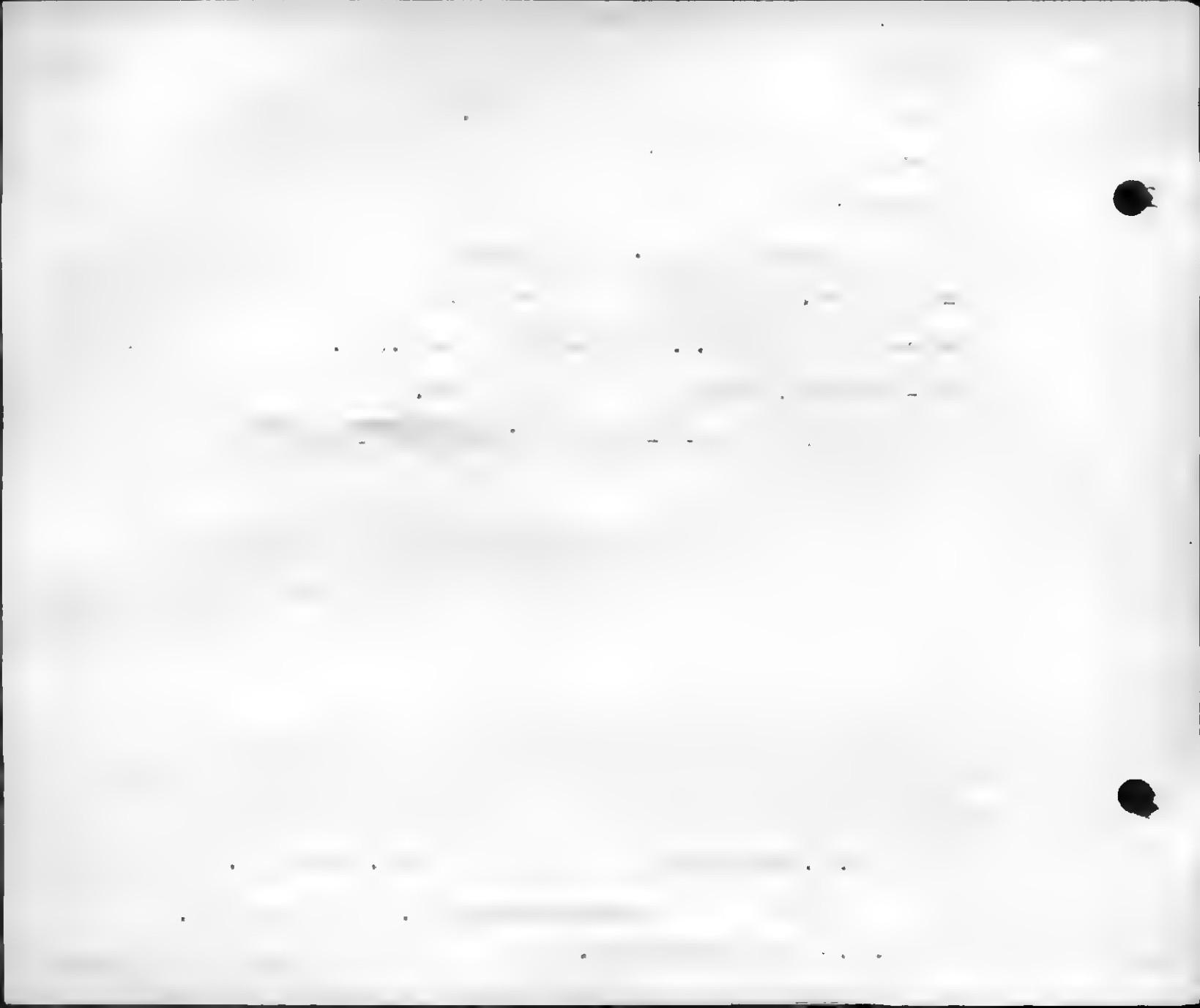
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 15286

4
06296

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 625 Myers Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 625 Myers Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William		First S.	Middle Herrick	Last Herrick	4. DATE OF DEATH May 20	Month May	Day 20	Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 29, 1887	9. AGE (in years last birthday) 79 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Late - William J. Herrick					14. MOTHER'S MAIDEN NAME Unk.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO WWI 219-14-0967	INFORMANT Mrs. Joseph Galkas		Address 625 Myers Drive - 21228					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					<i>Pants myocardial Failure</i>		INTERVAL BETWEEN ONSET AND DEATH 36 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Laryngectomy for Ca of Larynx								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 303 N. Rolling Rd.	20f. (City or town) Baltimore	(County) Md.	(State) Md.				
21. I certify that I attended the deceased from October , 1966, to May 20, 1967 , that I last saw the deceased alive on May 19 , 1967, and that death occurred at 7 A.M. from the causes and on the date stated above.					ADDRESS (Street, city or town, state) 303 N. Rolling Rd.				DATE SIGNED 5/20/67
ACTUAL SIGNATURE <i>D. C. MacLaughlin</i>		PHYSICIAN'S NAME (Type) D. C. MacLaughlin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/23/67	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. - 4101 Edmondson Ave.		ADDRESS		24a. REC'D BY REGISTRAR MAY 22 1967	24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT:

36297

16287

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. on Residence before admission) a. STATE Maryland		b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Baltimore 21234		d. STREET ADDRESS 2032 E. Joppa R.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Louise Sproull		First Louise	Middle Sproull	Last HILL	4. DATE OF DEATH May 11, 1967	Month May	Doy 11	Year 1967	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Mary 23, 1888	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months 78	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William A. Sproull		14. MOTHER'S MAIDEN NAME Elizabeth Chipley							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-12-2606A		17. INFORMANT William S. Hill		Address Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart Failure</i>						INTERVAL BETWEEN ONSET AND DEATH 17 Days			
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <i>Obstruction Septicemia Dehydration 25% Body 3rd Burn</i>									
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DECR BE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Nothing caught fire Resching over Electric stove</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, Factory, street, offce bldg, etc.) <i>Honey Carney Balto Md.</i>		20f. CITY OR TOWN (County) (State)	
20c. TIME OF MUR. Month Day Year <i>2:30 am May 11 1967</i>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.								Address (Street, city, town, or county) 5111/67	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Moreland Memorial		23d. LOCATION (City or Town) Baltimore Co.		(County) (State) Md.	
24. FUNERAL DIRECTOR H.W.Jenkins & Sons Co.				25a. REC'D. BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15ME (5) 6M 1/67									

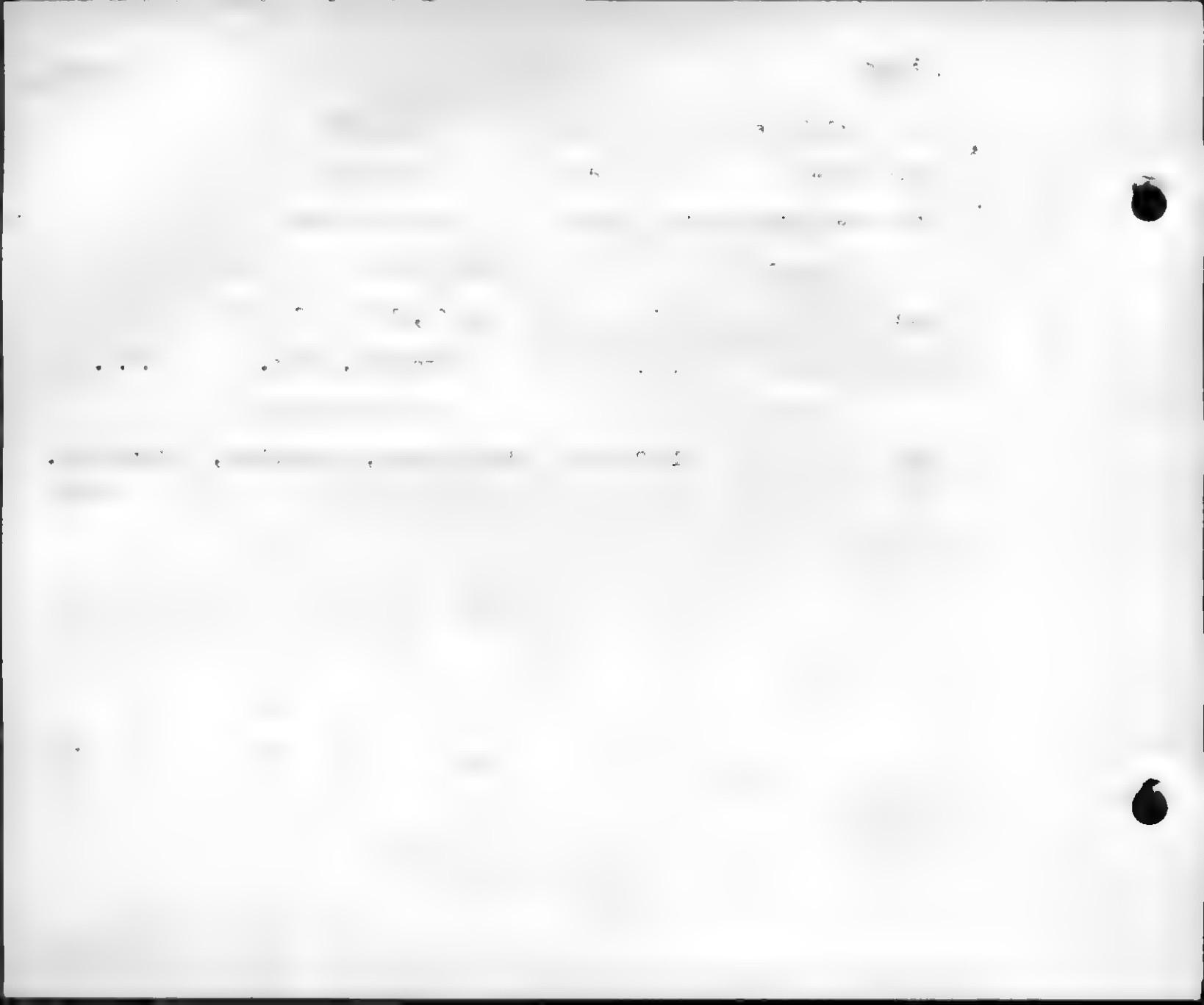


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #6 Film #146667 DC												CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 6 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 594A Yale Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital															
3. NAME OF DECEASED (Type or print)		First ALBERT		Middle L		Last HILLIARD		4. DATE OF DEATH Month May		Month 30		Doy 19	Year 67		
S. SEX	6. COLOR OR RACE Male White		7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1889		9. AGE (In years from last birthday) 78 yrs		FUNDER 1 YEAR Months 0		IF UNDER 24 HRS Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SOLDIER			10b. KIND OF BUSINESS OR INDUSTRY U. S. ARMY			11. BIRTHPLACE (County & State, or foreign country) Wimberding, Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Unk						14. MOTHER'S MAIDEN NAME VICTORIA MN: OGROWSKI									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO 218 26 33 06			17. INFORMANT Clinical Rcds, VA Hospital, Ft Howard Md.			Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA												INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)															
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CORONARY HEART DISEASE												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)												
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that (A) (this hospital) attended the deceased from May 24 , 19 67 to May 30 , 19 67 , that (I) (we) last saw the deceased alive on May 30 , 19 67 , and that death occurred on 10:30 AM from causes and on the date stated above.															
22a. SIGNATURE <i>Peter V. Juvan</i>			M.D. ATTENDING PHYS <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22b. DATE SIGNED 5/31/67						
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.			22d. ADDRESS VAH FORT HOWARD, MARYLAND												
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/2/67		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND								
24. FUNERAL DIRECTOR MC CULLY FUNERAL HOME FORT AVENUE, BALTIMORE, MD.			ADDRESS MC CULLY FUNERAL HOME FORT AVENUE, BALTIMORE, MD.			25a. REC'D BY REGISTRAR JUN 2 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

36299

CERTIFICATE OF DEATH

06289

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH

e. COUNTY
Baltimoreb. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Millsc. LENGTH OF STAY IN TB
10 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
11001 Reisterstown Road3. NAME OF DECEASED
(Type or print)

First JOHN

Middle BERNARD

5. SEX

Male

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bus Driver10b. KIND OF BUSINESS OR INDUSTRY
Balto. Transit11. BIRTHPLACE (County & State, or foreign country)
Owings Mills, Md.

13. FATHER'S NAME

John Hoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)
No

16. SOCIAL SECURITY NO.

213-05-9114

17. INFORMANT

Mrs. Kate E. Hoff, Owings Mills, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY
PERFORMED?
YES NO 19. WAS AUTOPSY
PERFORMED?
YES NO 20e. ACCIDENT WAS UNDERLYING ()
OR CONTRIBUTING () CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour o.m.
p.m.Month, Day, Year
1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-1-1967 to 5-15-1967, that (I) (we) last saw the deceased alive on 5-17-1967, and that death occurred at 5-17-1967 M. from the causes and on the date stated above

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)23b. DATE THEREOF
REMOVAL (Specify)
Burial 5/13/67

24 FUNERAL DIRECTOR'S SIGNATURE

H. J. Eckhardt

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

e. STATE
Maryland
b. COUNTY
Baltimorec. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills

d. STREET ADDRESS

11001 Reisterstown Road

e. IS RESIDENCE
ON A FARM?
YES NO

Last JOHN HOFF Month MAY Day 11 Year 1967

b. DATE OF BIRTH

Nov. 18, 1887

9. AGE (In years
last birthday)
79 yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.11. BIRTHPLACE (County & State, or foreign country)
Owings Mills, Md.12. CITIZEN OF WHAT COUNTRY?
U. S. A.

14. MOTHER'S MAIDEN NAME

Mary Lee Cantwell

11001 Reisterstown Rd.
Mrs. Kate E. Hoff, Owings Mills, Md.INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

22b. DATE
SIGNED
5-17-1967M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
22d. ADDRESS Reisterstown, Md.

23c. NAME OF CEMETERY OR CREMATORIAL

Druid Ridge Cemetery Pikesville, Md.

23d. LOCATION (City, town or county)
(State)

ADDRESS

Owings Mills, Md.

25e. REC'D. BY REGISTRAR

MAY 15 1967 Charles Judge

25b. REGISTRAR'S SIGNATURE

Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

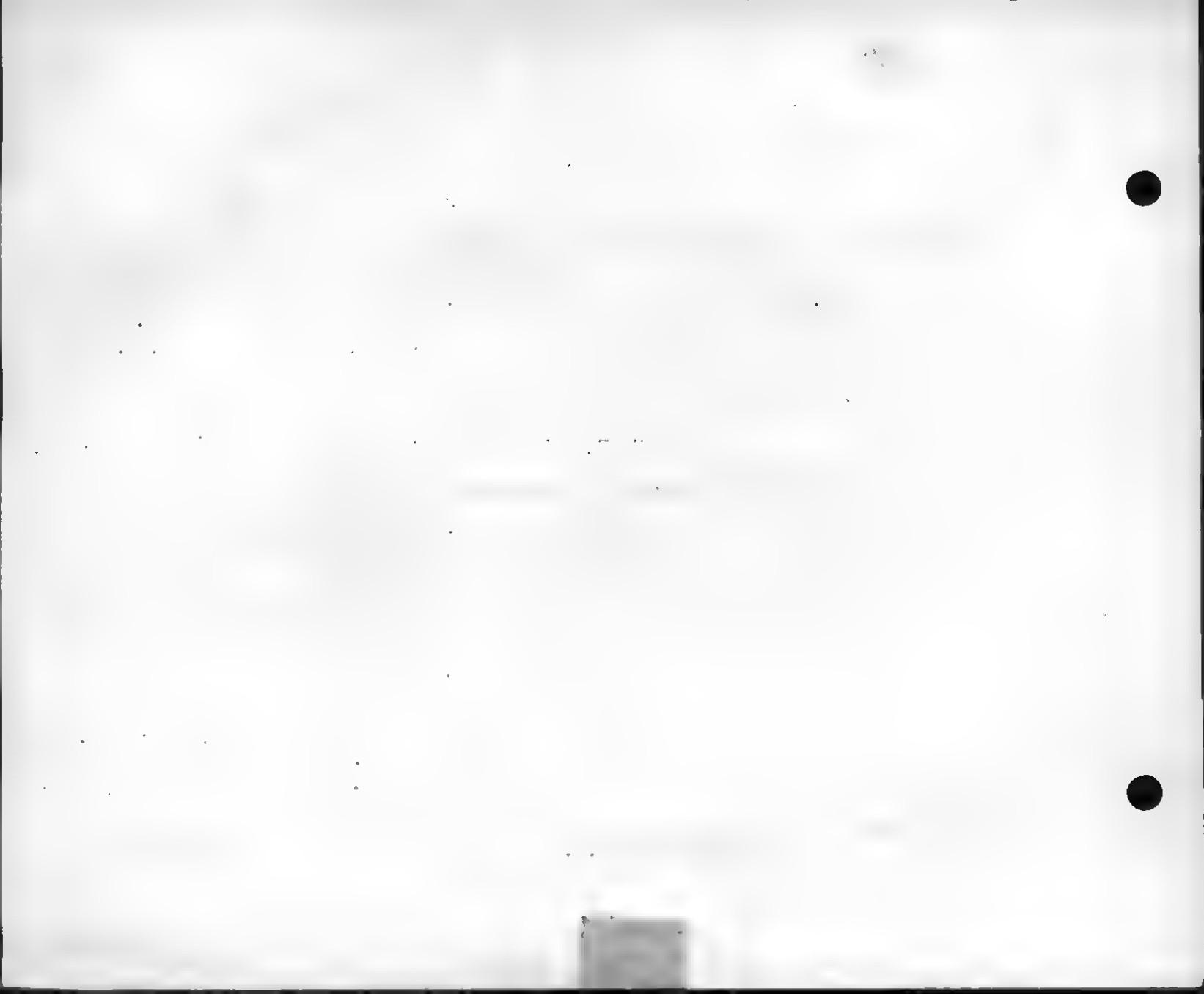
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file page 3 with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

JULY 1968

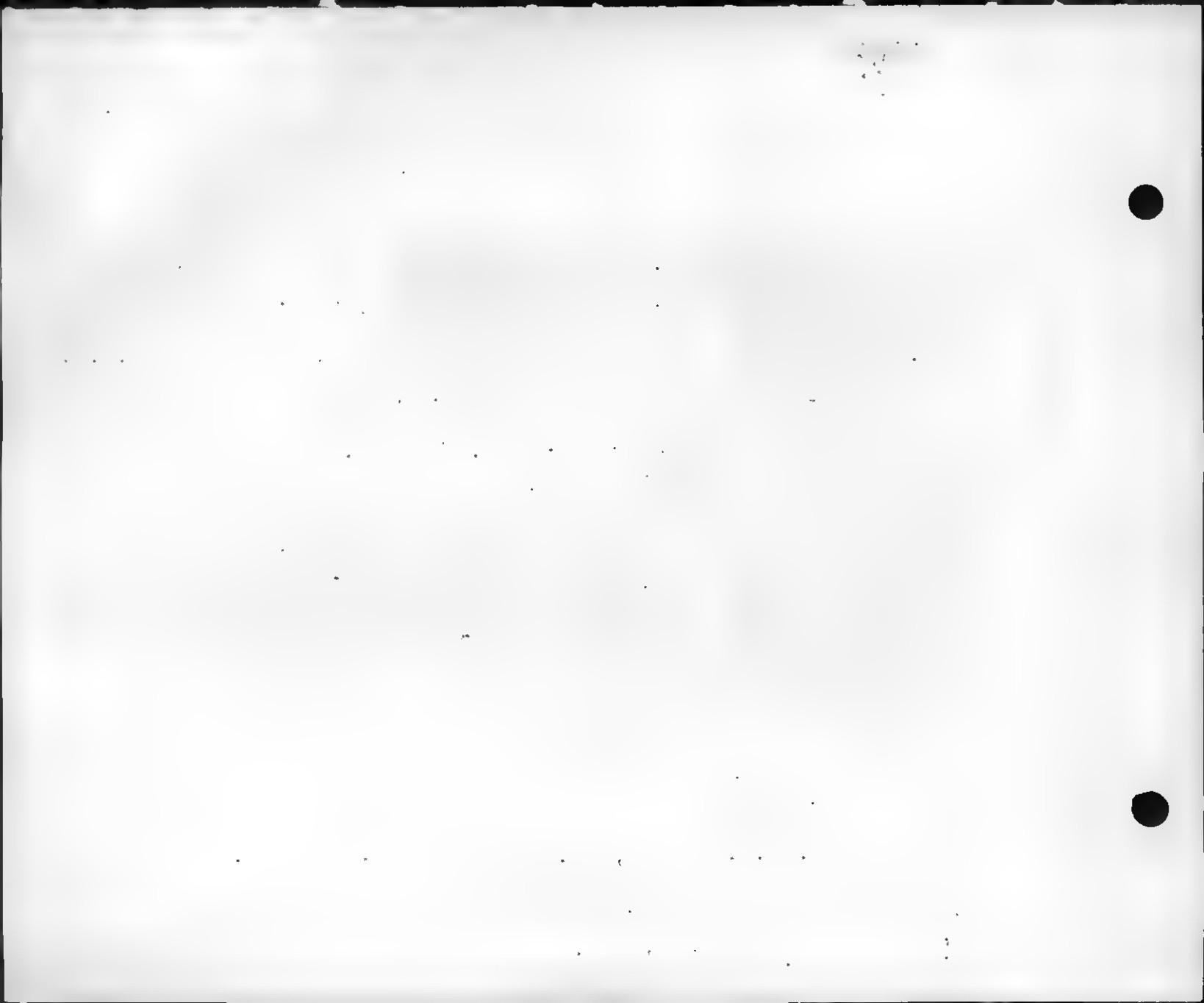
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 38yr11mth8dys				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						
3. NAME OF DECEASED (Type or print)	First Samuel	Middle Hoffman	4. DATE OF DEATH May 23 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1899			
9. AGE (In years last birthday) 67 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S.	13. FATHER'S NAME Samuel Hoffman	14. MOTHER'S MAIDEN NAME Annie Formen	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <input type="checkbox"/> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. 219-54-3163-T	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4601 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory	20f. (City or town) Baltimore	(County) Maryland	(State) 21228
21. I certify that (I) (this hospital) attended the deceased from June 15, 1967, to May 23, 1967, that (I) (we) last saw the deceased alive on May 23, 1967, and that death occurred at 7:25 A.M., from the causes and on the date stated above.				22a. SIGNATURE Stella Wachsler	22b. DATE SIGNED 5-23-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) -R.I.C.		23b. DATE THEREOF 5/26/1967	23c. NAME OF CEMETERY OR CREMATORIAL Mt. CORNEL	23d. LOCATION (City, town or county) BALTO MD		
24. FUNERAL DIRECTOR Sylvan S. LEWIS & Son, Inc - GARRISON MD		ADDRESS	25a. REC'D BY REGISTRAR DATE MAY 29 1967	25b. REGISTRAR'S SIGNATURE Charles J. George		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				3. LENGTH OF STAY IN 1b c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Baltimore MARYLAND				Maryland				Rodgers Forge									
b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY				c. LENGTH OF STAY IN 1b									
Rodgers Forge				Baltimore				Baltimore									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
37 Dunkirk Road				37 Dunkirk Road													
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH		Month Day Year					
CHARLOTTE T. HOGAN										May 27,		1967					
5. SEX				6. COLOR DR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.					
Female				White		WIDOWED <input checked="" type="checkbox"/>		Divorced <input type="checkbox"/>		November 8, 1880 86 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
Housewife				Home		Baltimore, Maryland											
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				Address									
Charles Rebstock				Charlotte													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				INTERVAL BETWEEN DEATH AND DEATH					
No				220-07-8044				Mrs. Marie H. LaFleur Same				26 yrs					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												260X					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)				Coronary Heart Disease				16 yrs					
DUE TO				DUE TO				Arteriosclerosis CC Disease				16 yrs					
(c)								A white female				16 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Reacted circumspectly by life end.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				19		While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1962 to May 1967, that (I) (we) last saw the deceased alive on May 10 1967, and that death occurred at 5 P.M. from the causes and on the date stated above.												22b. DATE SIGNED					
22a. SIGNATURE				Dr. E.P. Coffay, Jr.								22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS								22d. ADDRESS					
Dr. E.P. Coffay, Jr.				3100 St. Paul St. Baltimore													
23a. BURIAL, CREMATION OR REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION (City, town or county) (State)					
Burial				5-31-67				New Cathedral				Baltimore, Maryland					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Mitchell-Wiedefeld Home, Inc.								DATE JUN 1 1967				Charles Judge					
6500 York Rd.																	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06302

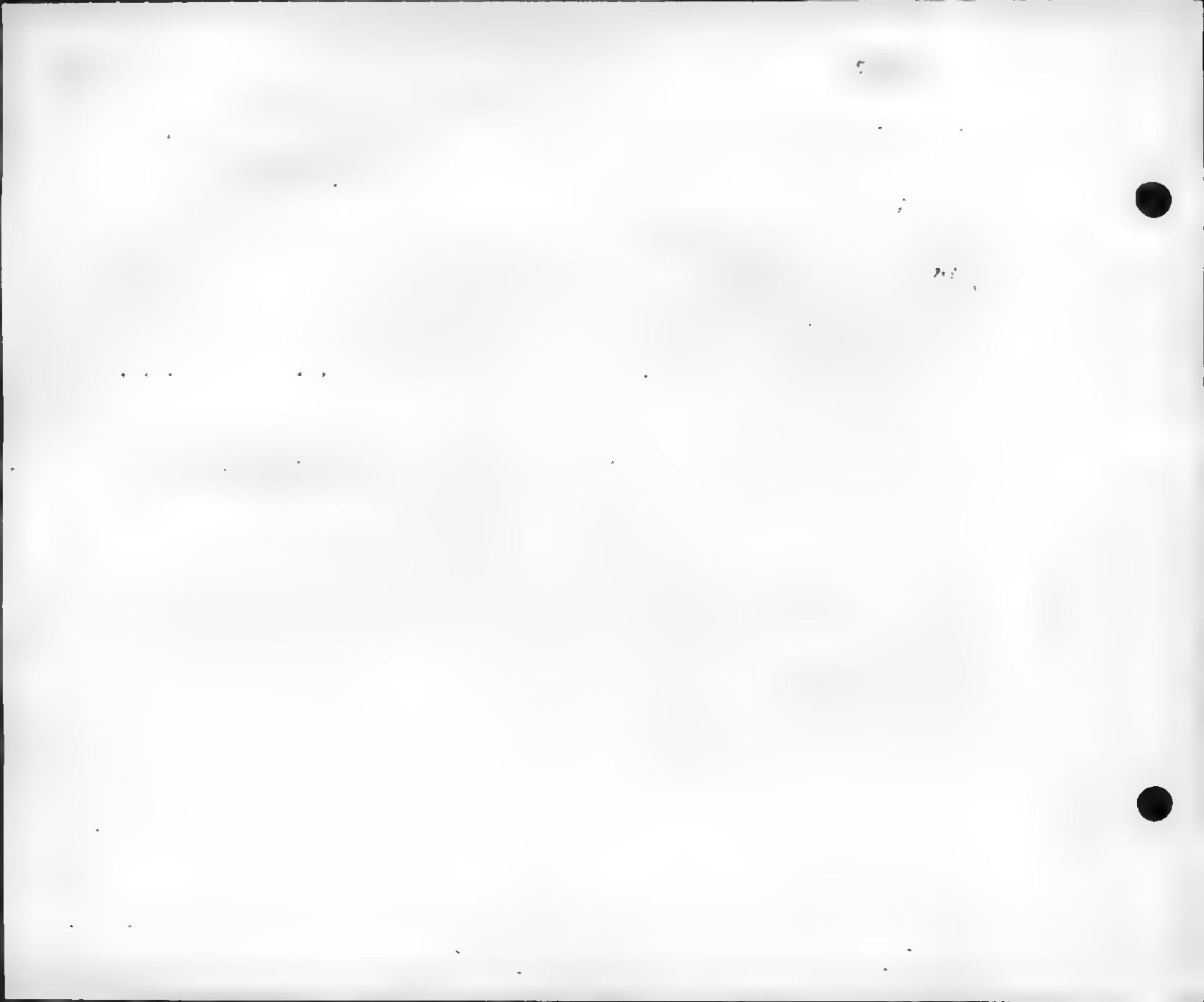
CERTIFICATE OF DEATH

16292

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Carrollton	
3 NAME OF DECEASED (Type or print) Margaret		First Margaret	Middle Cora
4 DATE OF DEATH Month MAY		Last Holson	Month Day Year 24 1967
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH April 17, 1910		9 AGE (In years last birthday) 57 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired Sales Clerk		10b KIND OF BUSINESS OR INDUSTRY Dept. Store	
11 BIRTHPLACE (County & State, or foreign country) Washington D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vernon Hayden		14. MOTHER'S MAIDEN NAME Mary King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 577-01-5526	
17. INFORMANT Barbara A. Petro 6109 85th Place Records Department, Spring Grove State Hospital		Address New Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE		INTERVAL BETWEEN ONSET AND DEATH	
4281 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
		DUE TO ARTERIOSCLEROSIS GENERALIZED AND SEVERE	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. Oct. 27, 1966		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spring Grove State Hospital
20f. (City or town) Baltimore		(County) (State) Maryland	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 27, 1966 to MAY, 24, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 24 1967 , and that death occurred at 6:33 P.M. from causes and on the date stated above.			
22a. SIGNATURE Morris Meiller		22b. DATE SIGNED May 24, 1967	
22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 27, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery
23d LOCATION (City or Town) Prince Georges Co., Md.		(County) (State)	
23e. FUNERAL DIRECTOR Thomas Schubert, Inc.		23f. ADDRESS 8434 Georgia Avenue Silver Spring, Md.	23g. RECEIVED BY REGISTRAR DATE MAY 26 1967
23h. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

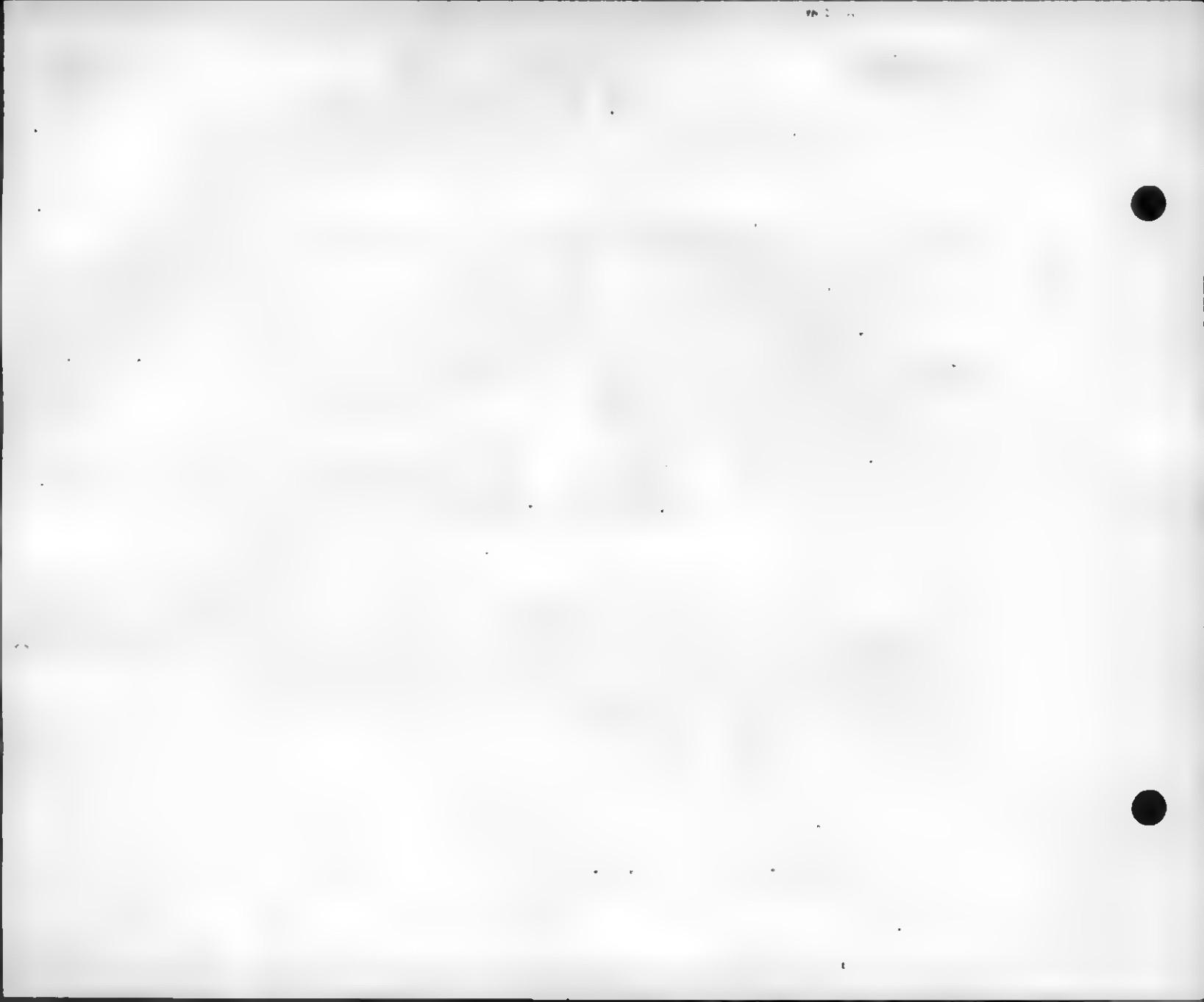
1
36303

CERTIFICATE OF DEATH

36293

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b 49 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 4302 KOLB AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) HENRY ALLARD HOLT		First	Middle	LAST	4. DATE OF DEATH MAY 10 1967	Month	Doy	Year
S SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/11/09	9. AGE (In years last birthday) 58 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR & SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) LOUISVILLE, KENTUCKY		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME WILLIAM HOLT		14. MOTHER'S MAIDEN NAME DAISY HOPKINS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> YES		16. SOCIAL SECURITY NO. HW II 215 03 10 95		17. INFORMANT CLINICAL RECORDS VAH FORT HOWARD, MARYLAND		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CTRRHOSIS OF THE LIVER				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b)						
		(c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 22, 1967 , to MAY 10, 1967 that (I) (we) last saw the deceased alive on MAY 10, 1967 , and that death occurred at 7:30 AM M. from causes and on the date stated above.								
22a. SIGNATURE <i>John D. Talbert</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-10-67				
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/12/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR ROBERT C. ALLENBURG		25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
6304

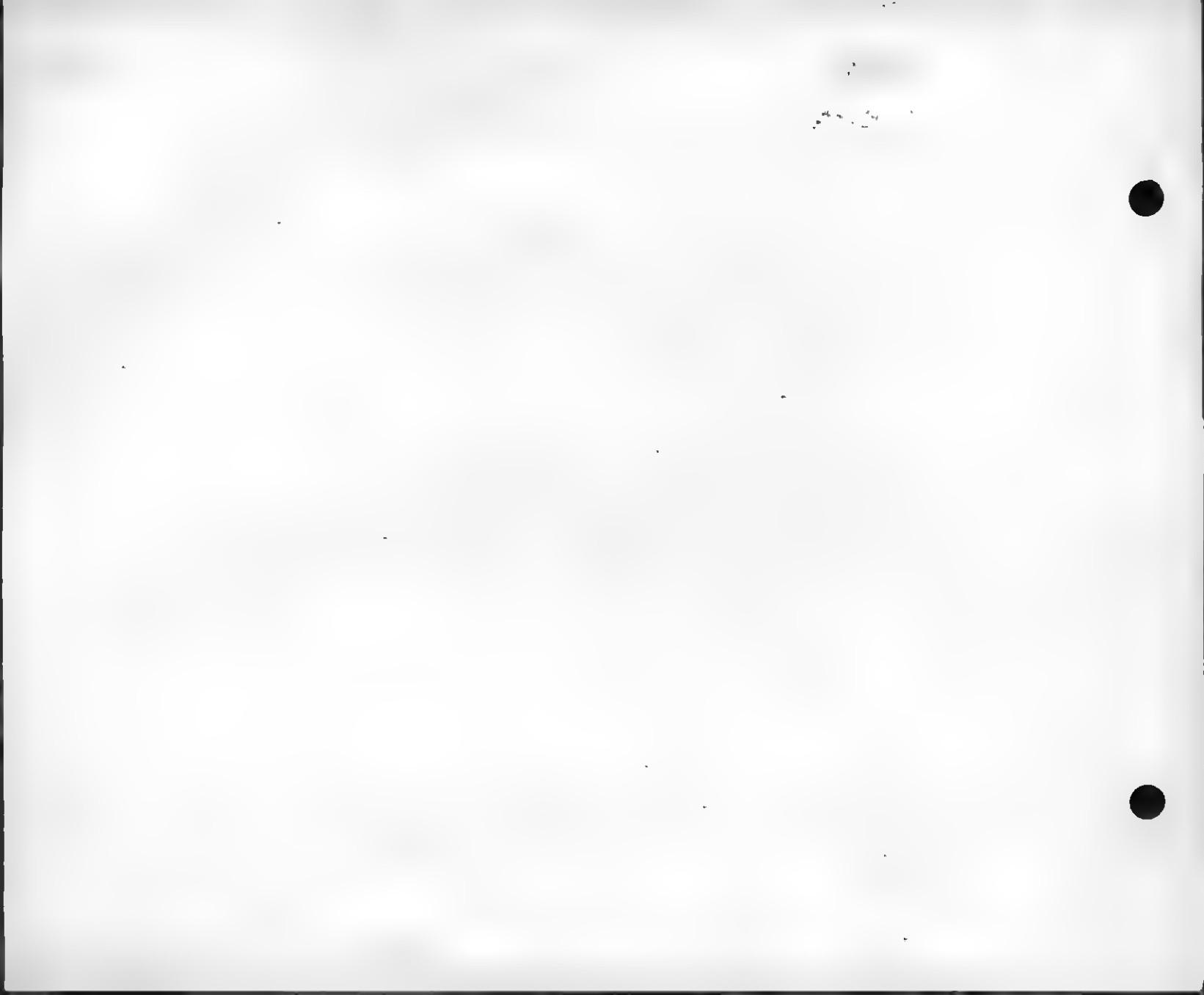
CERTIFICATE OF DEATH

DE294

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS 3725 Fairhaven Avenue					
3. NAME OF DECEASED (Type or print) JAMES FRANCIS HOLY		First	Middle	Last	4. DATE OF DEATH Month 5	Month 15	Day 19	Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/01	9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0		
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Michael Holy				14. MOTHER'S MAIDEN NAME Nocar Marie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO 214-44-6632	17. INFORMANT Family	Address Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple pulmonary emboli				INTERVAL BETWEEN ONSET AND DEATH 5 min.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic cardiovascular disease									
				DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS A POSTMORTEM EXAMINATION PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/8, 1967 , to 5/15, 1967 , that (I) (we) last saw the deceased alive on 5/15, 1967 , and that death occurred at 6 P.M. , from causes and on the date stated above.									
22a. SIGNATURE <i>John E. Adams</i>		MD ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED MAY 16, 1967					
22c. PHYSICIAN'S NAME (Type) John E. Adams		22d. ADDRESS 6701 North Charles Street Baltimore 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) A.A. Co. Md.			
24. FUNERAL DIRECTOR McCullough F.H. 237 Patapsco Ave		ADDRESS 21225		25a. REC'D. BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE John E. Adams			
VR A15 (4) 25M 1/67									



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

6305 RANDALLSTOWN CERTIFICATE OF DEATH

16305

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Baltimore County Hospital MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown, Md.		b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21207	
70 MIN.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTIMORE GENERAL COUNTY Hosp		d. STREET ADDRESS 3410-A Courtleigh Dr.	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Paul		Middle	Month
Last Homoki		Day	Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED	8. DATE OF BIRTH Aug 6, 1930
9. AGE (In years last birthday) 36 yrs		f. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) See Draynes		10b. KIND OF BUSINESS OR INDUSTRY Hunger	
11. FATHER'S NAME Andrew		12. CITIZEN OF WHAT COUNTRY? USA	
13. MOTHER'S MAIDEN NAME Blanche		14. Address Same	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-46-4082	
17. INFORMANT Veronica Homoki		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cardiac Arrest DUE TO lost (c) HAS CVD	
19. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-8-, 1967, to 5-8-, 1967, that (I) (we) last saw the deceased alive on 5-8- 1967, and that death occurred at 4:45 A.M., from causes and on the date stated above.			
22a. SIGNATURE Cesar Valle Caervo		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 5-8-67	
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 8, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Clergy Alans Chapel		23d. LOCATION (City or Town) (County) (State) Randallstown Md	
24. FUNERAL DIRECTOR Syman & Sons, Inc. Garrison, Md		ADDRESS	
25a. REC'D BY REGISTRAR MAY 10 1967		25b. REGISTRAR'S SIGNATURE Charles J. Judge	



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

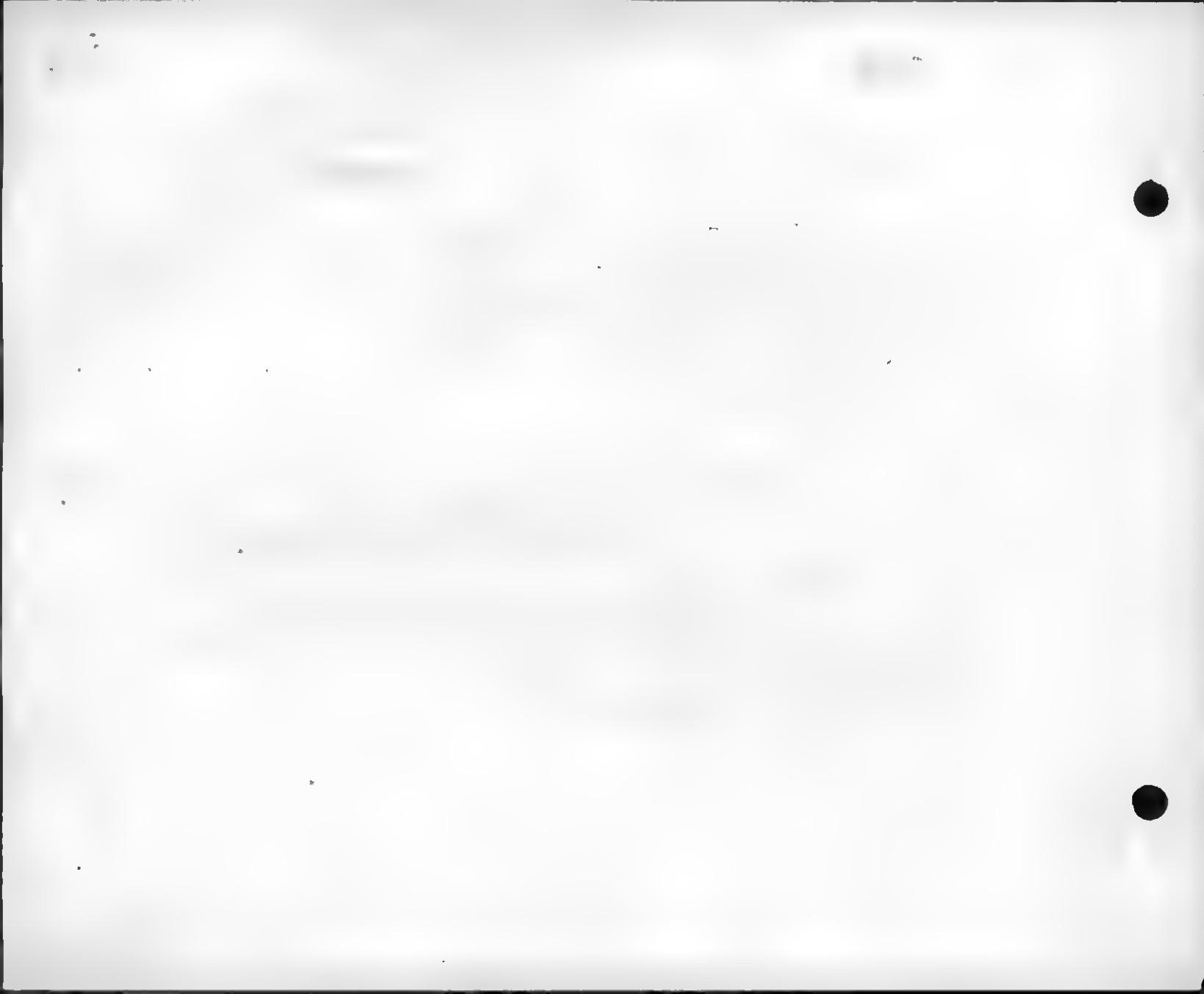
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06306

CERTIFICATE OF DEATH

06296

1. PLACE OF DEATH a. COUNTY Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb (2 yrs 11 mo. 14 days) Lansdowne, Maryland 21227	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines- Catonsville		d. STREET ADDRESS 242 Clyde Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Camilla E. Hopkins		4. DATE OF DEATH Lost May 27, 1967	Month Day Year
5. SEX Female White		6. COLOR OR RACE WIDOWED	7. MARRIED NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Augustus Selby		14. MOTHER'S MAIDEN NAME Mary Ridgely	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Catonsville, Md. 21228		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterosclerotic C V D, Marked, generalized</u> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 MO.	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Pneumonia, left lower lung	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/13/64</u> , 19 <u>19</u> , to <u>5/21/67</u> , 19 <u>19</u> , that (I) (we) last saw the deceased alive on <u>5/11/67</u> , 19 <u>19</u> , and that death occurred at <u>2:10 AM</u> , from causes and on the date stated above.		22b. DATE SIGNED 5/29/67 21229	
22c. SIGNATURE <u>Herbert J. Levickas</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 1073 Maiden Choice Lane Balt. Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Mountain View Cemetery
24. FUNERAL DIRECTOR Eastern Funeral Home		ADDRESS Catonsville, Md.	25a. REC'D. BY REGISTRAR MAY 31 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96307

CERTIFICATE OF DEATH

16
16307

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD		b. COUNTY BALTL.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN lb Mount 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDERWOOD				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 1716 WILLOW AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JAMES	Middle PINDELL	Last HOWARD	4. DATE OF DEATH Month 5	Month 14	Day 1967	Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/84	9. AGE (In years lost birthday) 82 yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - LABORER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME FRANK HOWARD		14. MOTHER'S MAIDEN NAME EMMA HEDERICK		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service UNKNOWN		16. SOCIAL SECURITY NO 711-05-2101		17. INFORMANT Records, Mount Wilson State Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO 4321 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBRAL INFARCTION DUE TO (c) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) ABDOMINAL AORTIC ANEURYSM		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		21. I certify that (I) (this hospital) attended the deceased from 5/13/67 to 5/14/67 , that (I) (we) last saw the deceased alive on 5/13/67 , and that death occurred at 0830 AM , from causes and on the date stated above.		22b. DATE SIGNED 5/14/67				
22c. PHYSICIAN'S NAME (as listed) Wm. Newcomer, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Mount Wilson, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 17 1967		23c. NAME OF CEMETERY OR CREMATORIUM Selassie's Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.		
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.		ADDRESS		25a. RECEIVED BY REGISTRAR DATE MAY 18 1967		25b. REGISTRAR'S SIGNATURE George Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

26308

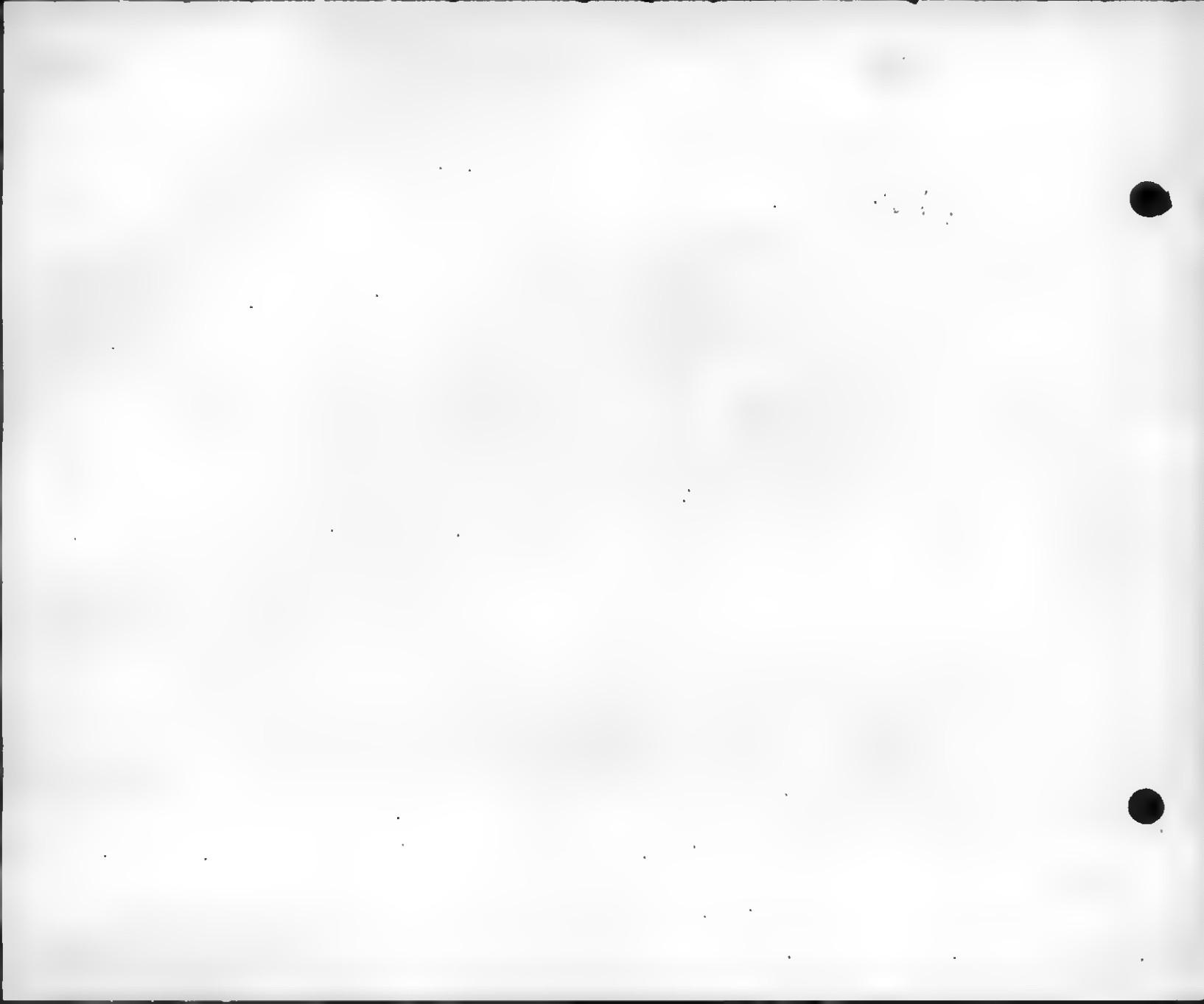
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CERTIFICATE OF DEATH

26308

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that all the death certificate be executed within 24 hours after death.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 103 PARK DRIVE		e. STREET ADDRESS 103 PARK DRIVE		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First JAMES	Middle G.	Last HOWELL	4. DATE OF DEATH Month 5	Month 24	Day 1967	Year		
5. SEX M	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7 1899	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOCTOR		10b. KIND OF BUSINESS DR INDUSTRY MEDICINE		11. BIRTHPLACE (County & State, or foreign country) ALBION PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE A.		14. MOTHER'S MAIDEN NAME MARGARET CONDRIN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 17. INFORMANT MRS. HOWELL			Address 103 PARK DRIVE
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 6MOS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE									
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) ST. AGNES HOSP, BALTO 21229 MD.	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from DEC 6, 1966 to MAY 27, 1967 , that (I) (we) last saw the deceased alive on MAY 24, 1967 , and that death occurred at 7:40 AM , from the causes and on the date stated above.		22a. SIGNATURE John H. Tuohy		22b. DATE SIGNED 5/24/67					
22c. PHYSICIAN'S NAME (Type) JOHN H. TUOHY, M.D.		22d. ADDRESS ST. AGNES HOSP, BALTO 21229 MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/27/67		23c. NAME OF CEMETERY OR CREMATORIAL OLD TRINITY		23d. LOCATION (city, town or county) CHURCH CREEK MD.		(State)	
24. FUNERAL DIRECTOR FARLEY-CAVANAUGH		ADDRESS 6601 FREDERICK		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 29 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06299

06303

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: C. E. EDWARDS FUNERAL HOME, BOWLING GREEN, VIRGINIA

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 113 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 1225 W. BALTIMORE STREET	
f. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First JAMES	Middle LLOYD	Last HUDSON
4 DATE OF DEATH MAY 24 1967/68	Month MAY	Do, Year 24 1967/68	Year
5 SEX MALE	6 COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH AUGUST 12, 1909
9 AGE (In years last birthday) 57 yrs	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Days 0	12 Hrs 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13. FATHER'S NAME EUGENE HUDSON		14. MOTHER'S MAIDEN NAME MAUDE ESLECK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO 218 07 56 57	
17. INFORMANT Address		18. CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>20a g</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC PULMONARY EMPHYSEMA WITH RESPIRATORY FAILURE UNKNOWN		22. DUE TO (b) PULMONARY TUBERCULOSIS, FAR ADVANCED, INACTIVE	
23. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) COPULMONALE			
24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		25. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
26. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		27. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH FORT HOWARD, MARYLAND
29. (b) I certify that (I) (this hospital) attended the deceased from 1/31/67 , 19, to 5/24/67 , 19, that (we) last saw the deceased alive on 5/24/67 , 19, and that death occurred at 8:00P M, from causes and on the date stated above.		30. (c) DATE SIGNED 5/25/67	
31. SIGNATURE <i>Peter V. Juvan</i>		32. ADDRESS M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
33. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		34. DATE THEREOF 5-28-67	
35. NAME OF CEMETERY OR CREMATORIAL SPARTA CEMETERY		36. LOCATION (City or Town) SPARTA, VIRGINIA	
37. FUNERAL DIRECTOR ELROY O WILSON FUNERAL HOME		38. REC'D. BY REG. STRAR MAY 26 1967	
39. ADDRESS ORLEANS ST. BALTIMORE, MD.		40. REGISTRAR'S SIGNATURE <i>Charles Juvan</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06310

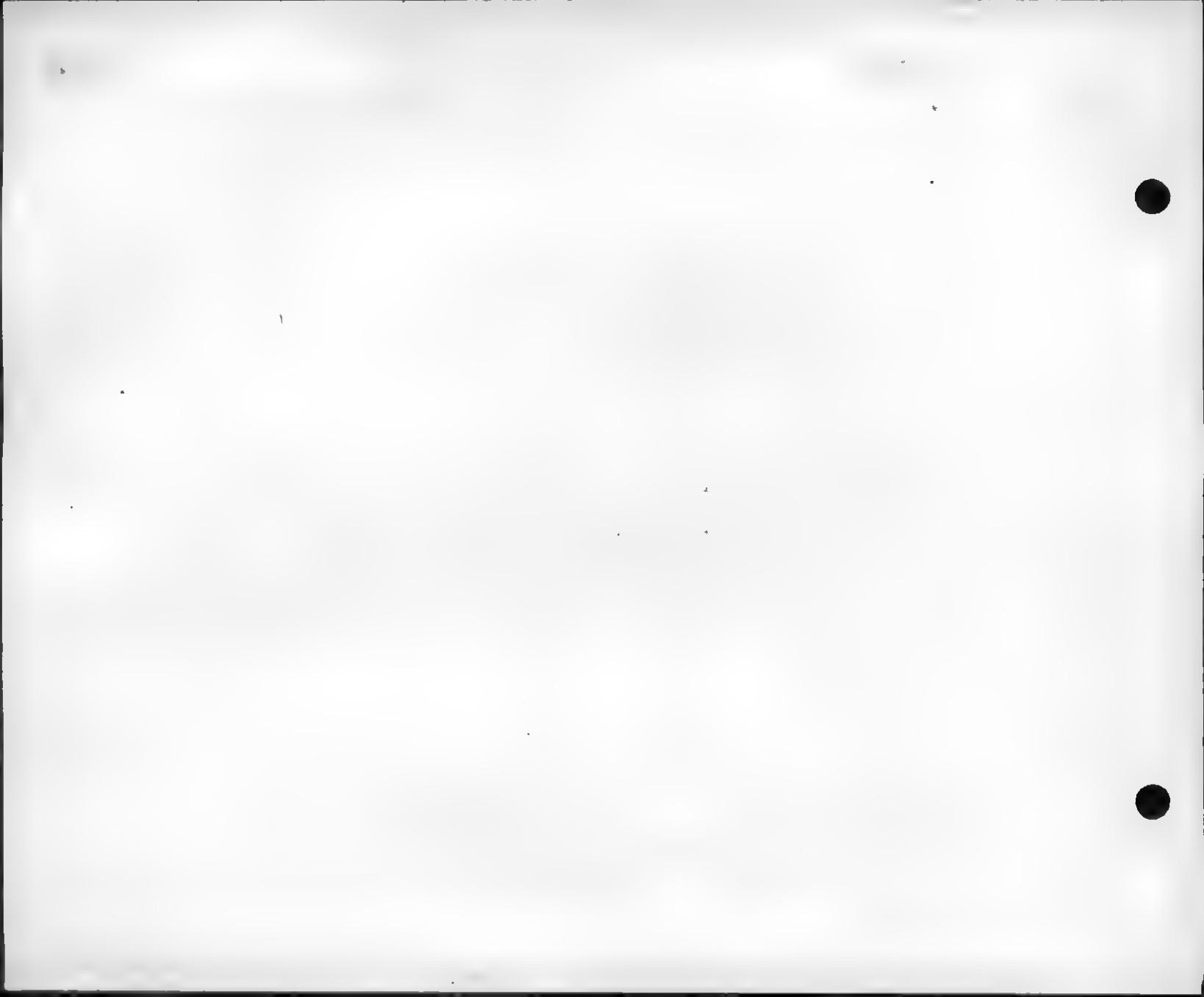
CERTIFICATE OF DEATH

DE300

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
PAGE 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore County		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland		b COUNTY Worcester			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c LENGTH OF STAY IN lb 2 1/2 mo.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville		d STREET ADDRESS B7D.			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital						e S RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) WALTER JAMES HUDSON		First	Middle	Lost	4. DATE OF DEATH 11.22.1915	Month 5.	Day 10.	Year 1967.	
5. SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	<input checked="" type="checkbox"/> DIVORCED	B. DATE OF BIRTH 11.22.1915	9 AGE (In years last birthday) 57 yrs	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Hours 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b KIND OF BUSINESS OR INDUSTRY Farmer		11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WALTER HUDSON		14. MOTHER'S MAIDEN NAME EVELYN TURNER		Address Records, Mount Wilson State Hospital					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-34-7238		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung with multiple metastasis DUE TO 16x Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 year
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bishopville	(County) Worcester	(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 2.21. , 19 67 to 5.10. , 19 67 that (I) (we) last saw the deceased alive on 5.10. 1967 , and that death occurred at 4:20 P.M. from causes and on the date stated above.		22a. SIGNATURE W. Newcomer							
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D.		22d. ADDRESS Superintendent Mount Wilson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/67	23c. NAME OF CEMETERY OR CREMATORIAL J.G.A.F.	23d. LOCATION (City or Town) Bishopville Worcester Md.			(County) Worcester	(State) Md.	
24. FUNERAL DIRECTOR Lester Whaley Sillymills Del.		ADDRESS		25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06311

CERTIFICATE OF DEATH

06301

1. PLACE OF DEATH

a. COUNTY

Baltimore

b. CITY OR TOWN (For out of corporate limits, write RURAL and give nearest town)

Overlea

MARYLAND

c. LENGTH OF STAY IN TB

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

7208 Linden Avenue

3. NAME OF

(Type or print)

First

Middle

SALLIE

F.

Last

HYMAN

4. SEX

F.

6. COLOR OR RACE

N.

7. MARRIED **NEVER MARRIED**

WIDOWED

DIVORCED

4. DATE OF DEATH

1-25-1899

Month

5

Day

22

Year

19 67

9. AGE (In years last birthday)

68 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State or foreign country)

WINDSOR, NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Solomon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank or date of service)

Address

Mrs. Mable Williams 7208 Linden Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Carcinomatosis
Carcinoma of Cervix

INTERVAL BETWEEN
ONSET AND DEATH

6 mos.
5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) **19. WAS AUTOPSY PERFORMED?**

YES NO

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

Month

Day

Year

p.m.

While at work Not While at work

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20e. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1 1967 to January 24 1967, that (I) (we) last saw the deceased alive on May 21 1967, and that death occurred 2 A.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

G. M. BAUMGARDNER

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

5/23/67

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

5-25-67

23c. NAME OF CEMETERY OR CREMATORIUM

Hill Auburn Cem.

23d. LOCATION (City, town or county)

Baltimore

(State)

rd

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE

MAY 24 1967

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

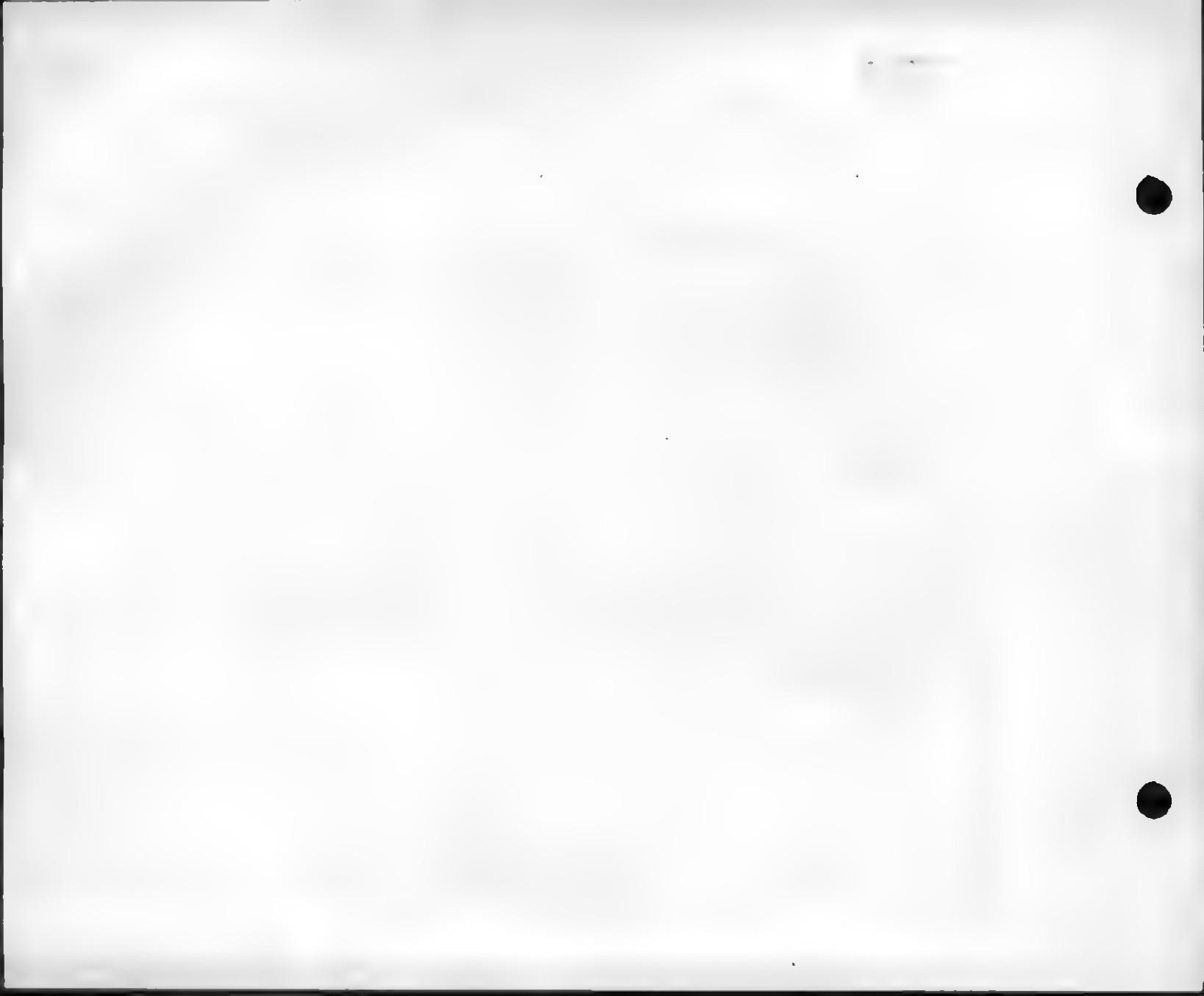
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may be retained by the hospital or attending physician.

36312

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore County			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson			c. LENGTH OF STAY IN 1b 6 months.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
f. STREET ADDRESS 1301 W. Pratt St.			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)		First FRANK	Middle GREEN	Last JACOBS	4 DATE OF DEATH Month Day Year 5 / 4 / 1967
5 SEX M.		6 COLOR OR RACE White	7 MARRIED WIDOWED Separated	8. NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	9. DATE OF BIRTH 5/25/05
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Robert Jacobs		14. MOTHER'S MAIDEN NAME Beverly Anthony			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 227-07-9331		17. INFORMANT Address Records, Mount Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulm. TB, FA, Octive. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO Rt. pleural effusion, TB. (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Alcoholism					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/15/66 , to 5/4/1967 , that (I) (we) last saw the deceased alive on 5/4/1967 , and that death occurred 5/4/1967 M, from causes and on the date stated above.					
22o. SIGNATURE Wm. Newcomer		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/4/67		
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D.		22d. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, Cremation, Removal (Specify) 5-7-67		23b. DATE THEREOF 5-7-67	23c. NAME OF CEMETERY OR CREMATORIAL Peaverdam Ch Cent	23d. LOCATION (City or Town) Goodview, VA	(County) (State)
24. FUNERAL DIRECTOR Newell Funeral Home, Elkton		ADDRESS Elkton - 8-116		25a. REC'D BY REGISTRAR MAY 9 1967	25b. REGISTRAR'S SIGNATURE Charles J. Hayes



May 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

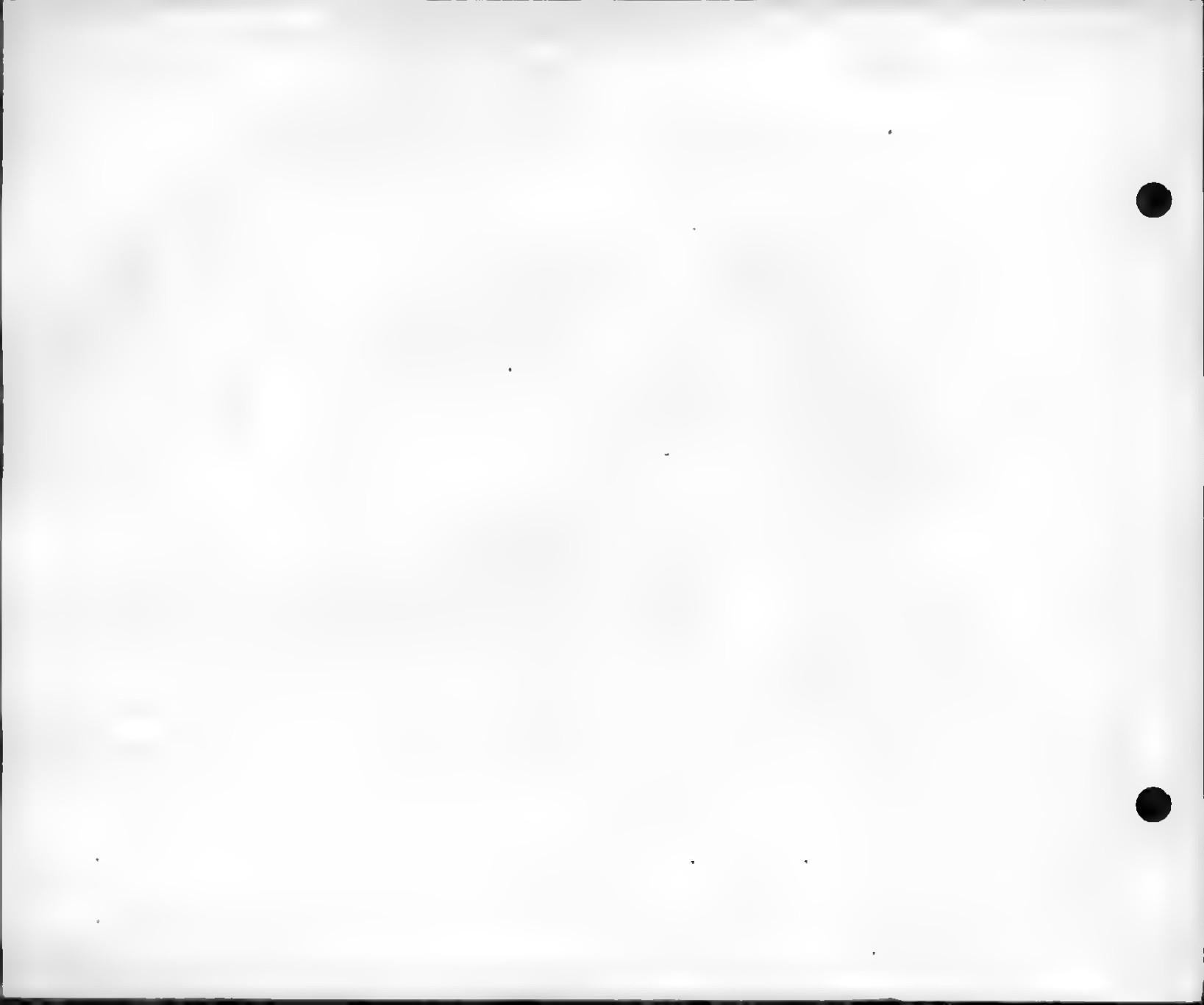
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06313

CERTIFICATE OF DEATH

06303

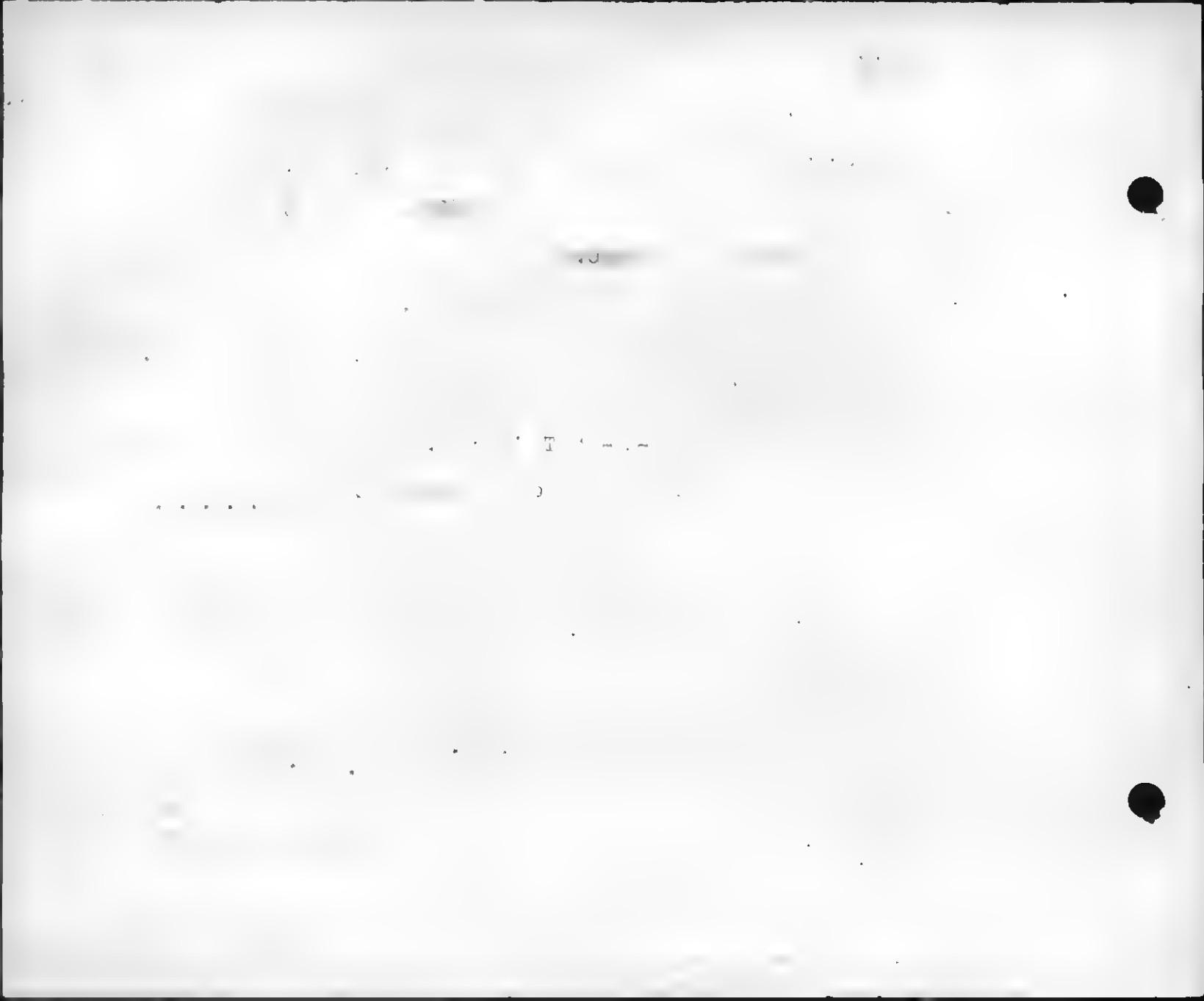
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Md., 21206 b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7911 Elmhurst Ave.		d. STREET ADDRESS 7911 Elmhurst Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FIRST RICHARD MIDDLE WILSON LAST JACOBS		4. DATE OF DEATH May 21 Month Day Year 19 67	
5. SEX male white		6. COLOR OR RACE 7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> B. DATE OF BIRTH 12/25/12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Fisher Body Co.	
10c. FATHER'S NAME Richard J. Jacobs		11. BIRTHPLACE (County & State, or foreign country) Virginia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-4514	
17. INFORMANT Mary S. Propst, mother, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH immediate DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) CARCINOMA PHARYNX 6 months DUE TO lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 1012 Old North Point Rd. (County) Sandersville (State) Va.	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1966 , to May 21, 1967 , that (I) (we) last saw the deceased alive on May 18, 1967 , and that death occurred at 10 AM , from causes and on the date stated above.		22b. DATE SIGNED May 22, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. John B. Littleton		22d. ADDRESS 1012 Old North Point Rd.	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5/25/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sangersville Cemetery		23d. LOCATION (City or Town) (County) (State) Sangersville, Va.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. RECEIVED BY REGISTRAR MAY 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY Baltimore				a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 22yr6mth15 days									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Loretta				Last C. James				4. DATE OF DEATH May 19 1967					
5. SEX female				6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10, 1891		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Bezold				14. MOTHER'S MAIDEN NAME Theresa Peters									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 220-46-0264				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Ruptured aortic aneurysm due to generalized A.S. + V.D.								INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b)													
DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of the Breast.													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 16 1944 to May 19 1967 , that (I) (we) last saw the deceased alive on May 19 1967 , and that death occurred at 5:10 P.M. from the causes and on the date stated above.													
22a. SIGNATURE Vicente M. Ruiz				22b. DATE SIGNED May 20, 1967									
22c. PHYSICIAN'S NAME VICENTE M. RUIZ				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/23/67				23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Wm. J. Tinkard Sons mort. & Pa				ADDRESS Buffalo, Md.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE			
								DATE 23 1967					



1 8

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

DE305

96315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has completely filled in by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		< LENGTH OF STAY IN lb 3 days		b. COUNTY Baltimore	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rt. 1, Cockeysville, 21030			d. STREET ADDRESS Box 355, Happy Hollow Road		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print)		First William	Middle Lamont	Last JAMES	4 DATE OF DEATH Month May Day 16 Year 19 67
S SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH June 14, 1912	9 AGE (In years last birthday) 54 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Oxygen		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME David James			14. MOTHER'S MAIDEN NAME Innie Jones		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO 166-09-9411		17. INFORMANT: wife Mary J. James, Cockeysville, Md.	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, left hemisphere DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 443 X Hypertension (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerotic cardiovascular disease					
INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 13 , 19 67 , to May 16 , 19 67 not <input type="checkbox"/> (we) lost sight of the deceased alive on May 16 , 19 67 , and that death occurred at 10 P.M., from causes and on the date stated above.					
22a. SIGNATURE <i>cockburn</i> , M.D.					
22c. PHYSICIAN'S NAME (Type) Manuel Cockburn, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED May 16, 1967	
22d. ADDRESS 7600 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/19/1967		23c. NAME OF CEMETERY OR CREMATORIUM Springhill Cemetery	
24. FUNERAL DIRECTOR Stewart & Bowen Co., 108 N. North Av., Balt.		ADDRESS 21201		25a. REC'D BY REGISTRAR Easton, Maryland	
				25b. REC'D BY STRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 15206

1. PLACE OF DEATH ■ COUNTY Baltimore		MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		21222
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Centre Avenue		d. STREET ADDRESS 8 Centre Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First MAX	Middle (NMN)	Last JANOWICH	4. DATE OF DEATH	Month May Day 18th, Year 1867
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1886	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landlord		10b KIND OF BUSINESS OR INDUSTRY Property Mgt.		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME (unknown) Janowich		14 MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no or unknown) no		16. SOCIAL SECURITY NO 218-03-8374A		17. INFORMANT Steve Janowich Box 672-Route 15 Address Baltimore, Md., 21220	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Throat DUE TO 148X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Pulmonary & Hepatic DUE TO Infiltrate (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
INTERVAL BETWEEN ONSET AND DEATH					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 19			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 105 Main Street (County) Baltimore, Maryland (State)
21. I certify that I attended the deceased from 5/17/67 to 5/18/67 , that I last saw the deceased alive on 5/17/67 , and that death occurred at 105 Main Street , Baltimore, Maryland, on the date stated above. ADDRESS (Street, city or town, state) 105 Main Street ACTUAL SIGNATURE Theodore C. Patterson DATE SIGNED 5/19/67					
PHYSICIAN'S NAME (Type) Theodore C. Patterson, M.D. Baltimore, Maryland 21222					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/20/67	22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery	22d. LOCATION (City, town, or county) Baltimore Co., Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley		ADDRESS Inc., Dundalk 22	24a. REC'D BY REGISTRAR MAY 22 1967	24b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

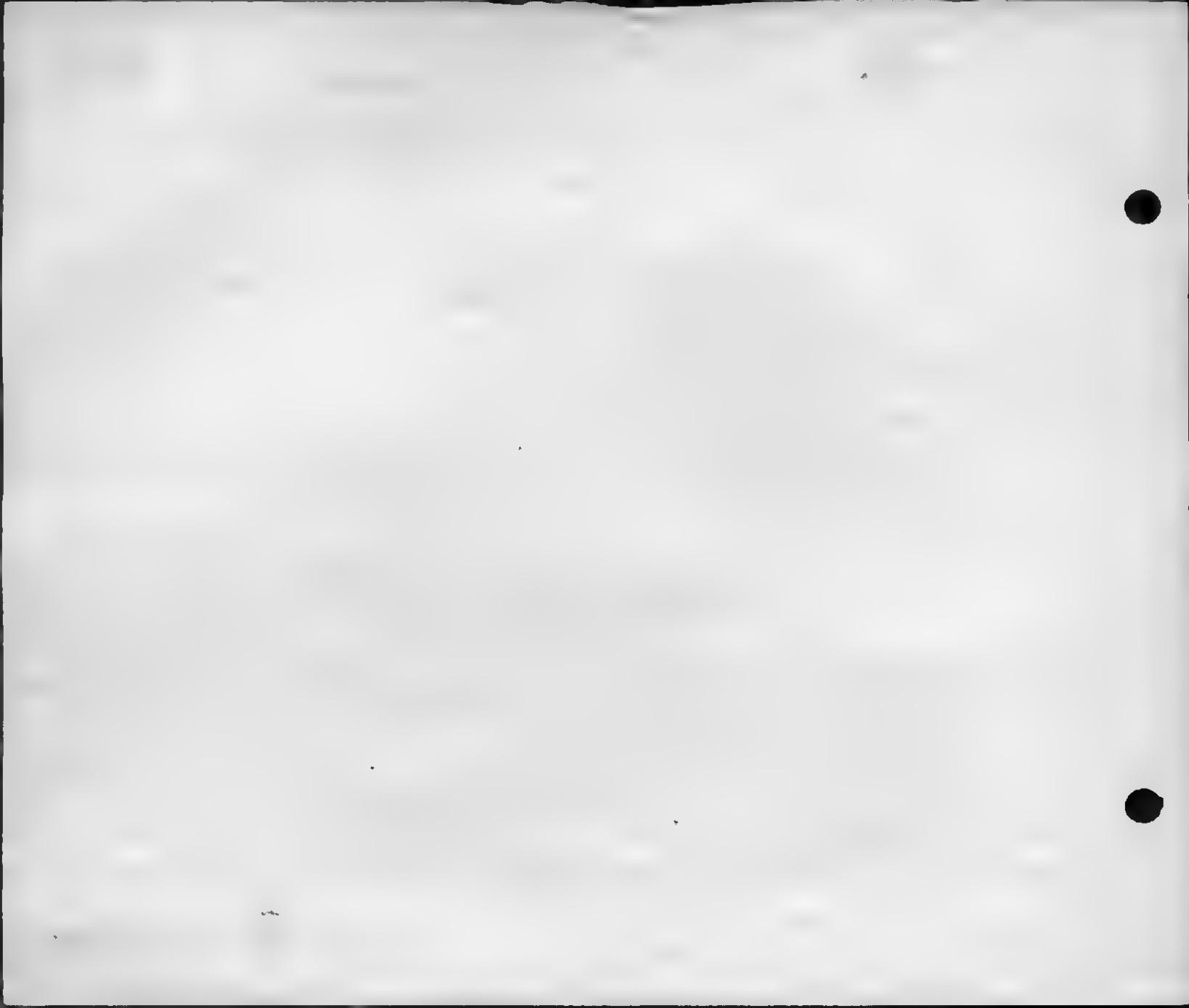
CERTIFICATE OF DEATH

09307

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

26317					
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)			
Baltimore		a. STATE Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge		b. COUNTY Baltimore			
c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5500 -B- Race Road		d. STREET ADDRESS 5500 -B- Race Road			
3. NAME OF DECEASED (Type or print) First Ellen Middle Roberta		4. DATE OF DEATH Month Day Year			
5. SEX Female Color Colored		5. COLOR OR RACE 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH October, 11, 1911 9. AGE (in years last birthday) 55 yrs.			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home			
11. BIRTHPLACE (County & State, or foreign country) Elkridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Taylor		14. MOTHER'S MAIDEN NAME Fannie S. Robinson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Mr. Allen Jarvis Jr 5500 -B- Race Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 581.0 DUE TO <i>Cirrhosis of liver</i>		unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } (b) DUE TO <i>Escharizing Hemorrhages</i>					
} (c) DUE TO <i>Cardio Vascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1967, to <i>May 4</i> , 1967, that (I) (we) last saw the deceased alive on <i>May 4</i> , 1967, and that death occurred at <i>8:03M</i> , from the cause and on the date stated above.					
22a. SIGNATURE <i>B.B. Brumbaugh M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>27/2/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>B.B. Brumbaugh M.D.</i>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>5/8/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.	
23d. LOCATION (City, town or county) <i>Baltimore, Maryland</i>				(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert S. Witten</i>		ADDRESS <i>3232 W. Fort Ave Baltimore, Md</i>		25a. REC'D. BY REGISTRAR <i>MAY 8</i> 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

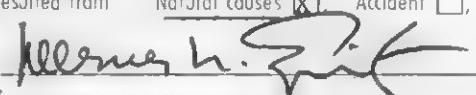


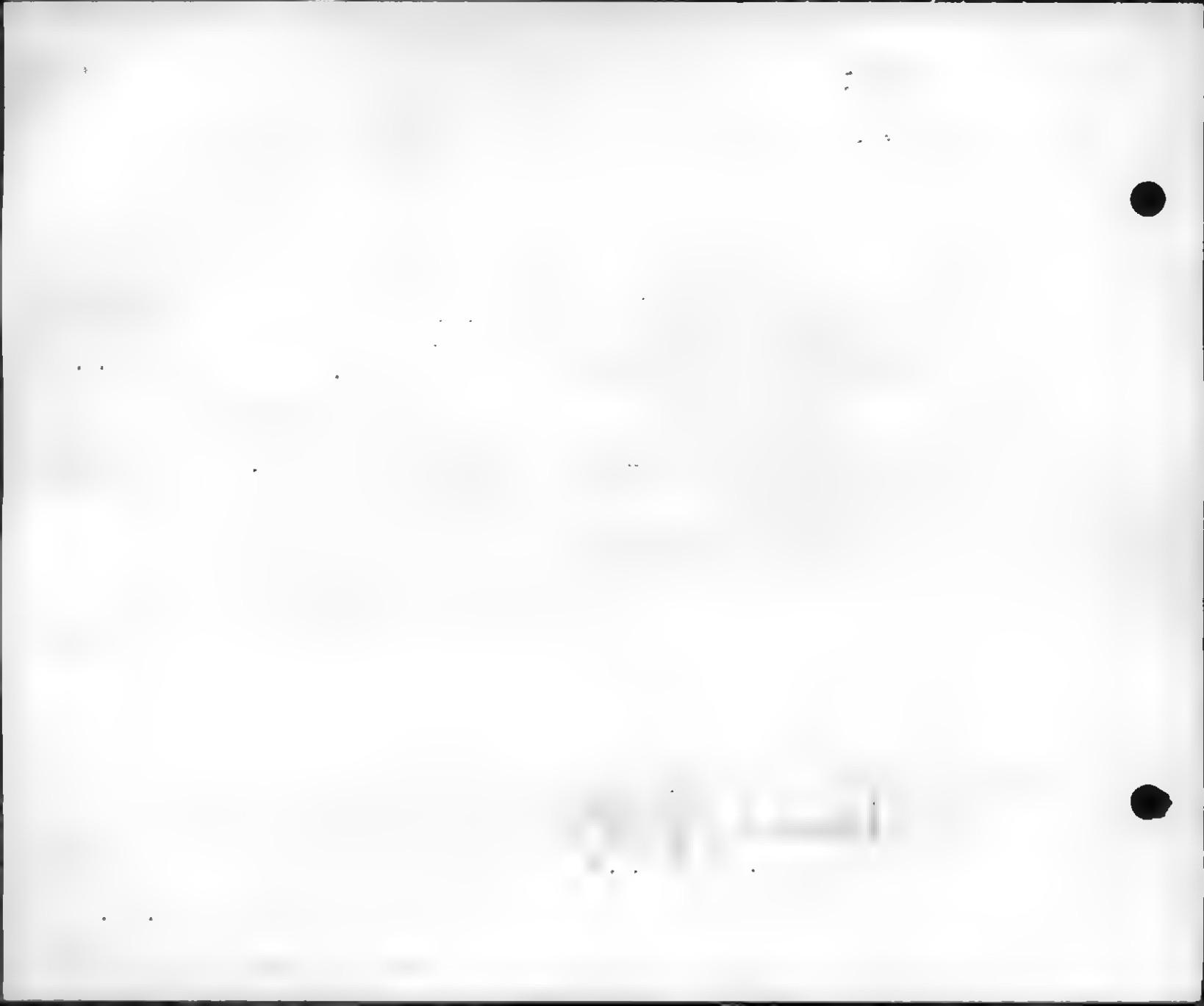
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

~~FOR STATE
HEALTH DEPT.~~

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH								26208	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN lb yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 525 Old Home Road				d. STREET ADDRESS 525 Old Home Road 36				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROLAND LEE JONES		First	Middle	Lost	4. DATE OF DEATH Month 5	Month 9	Doy 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED X NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-1905	9. AGE (In years lost birthday) 62 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS DAYS 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft		10b. KIND OF BUSINESS OR INDUSTRY Boeing Aircraft		11. BIRTHPLACE (State or foreign country) Denton, Md.			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Carrie Anthony					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-12-2416		17. INFORMANT Mrs Clara Figgs 1503 W. 36th Street		Address 21211			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cirrhosis of liver 10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(c)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> Part I
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCR BE HOW NJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month Day, Year Hour am pm 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF NJURY (Home farm factory, street, office bldg. etc.) Partial		20f. (City or town, County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									22. DATE SIGNED 5-9-67
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		Address (Street, City, town or county) 36							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-12-1967		23c. NAME OF CEMETERY OR CREMATORIUM Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.			
24. FUNERAL DIRECTOR Lazarus Funeral Home 240 Belair Road		ADDRESS 36		25a. REC'D BY REGISTRAR MAY 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15ME (5) 6M 1/67									



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or within 72 hours after death.

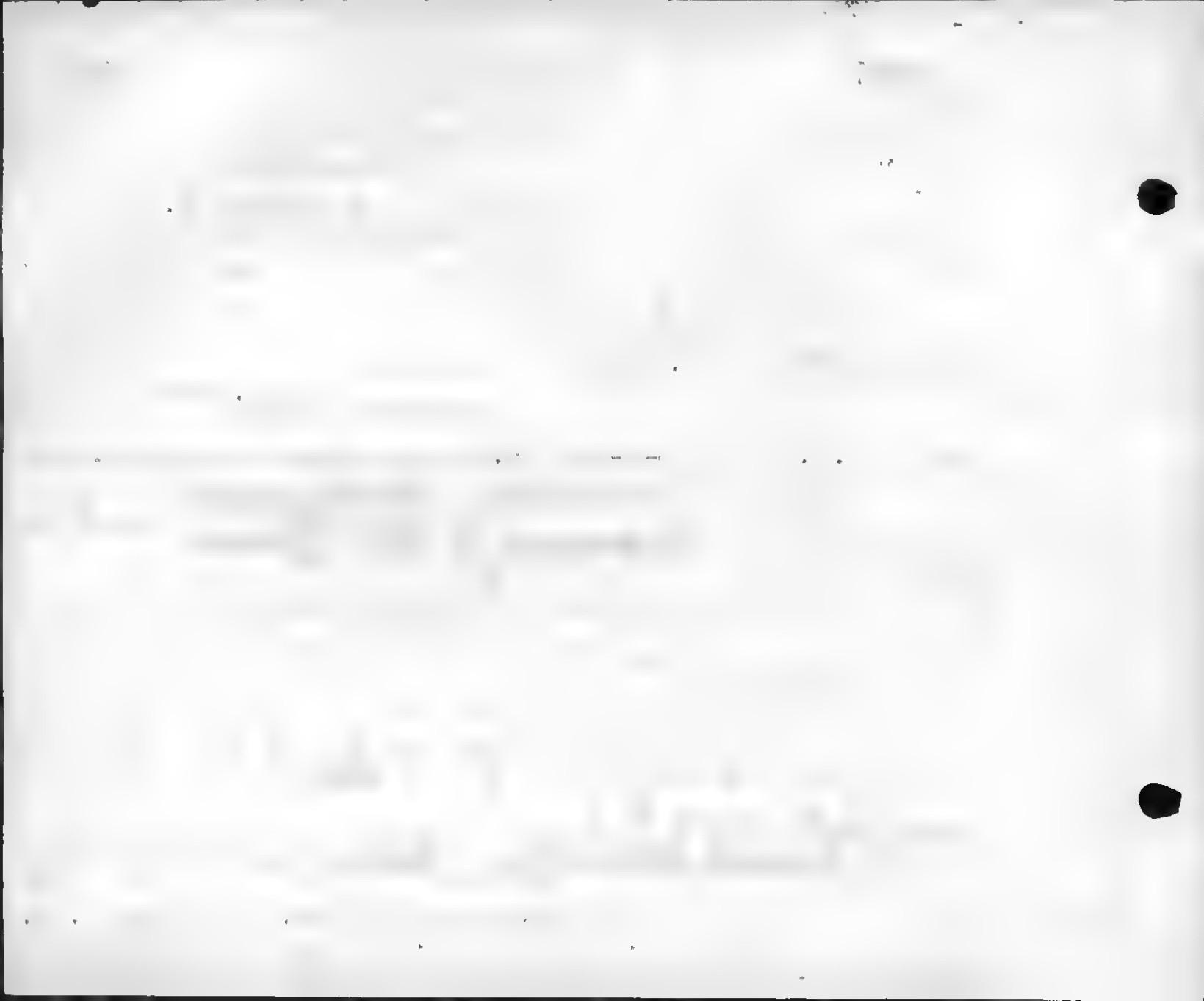
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #6 Film #G 8-161772c

06313

CERTIFICATE OF DEATH

1967

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 21207</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore County General Hospital</i>		d. STREET ADDRESS <i>4104 Buckingham Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Thomas</i>	Middle <i>B.</i>	Last <i>Jones</i>
4. DATE OF DEATH <i>5 12 67</i>	Month <i>5</i>	Day <i>12</i>	Year <i>67</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-11-24</i>
9. AGE (In years last birthday) <i>42 yrs</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Maintenance Office</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Thomas B. Jones, Sr.</i>	14. MOTHER'S MAIDEN NAME <i>Sarah A. Crabill</i>	Address <i>Dickenson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes	16. SOCIAL SECURITY NO. <i>W. W. II 225-28-0442</i>	17. INFORMANT <i>Mrs. Deborah Jones-4104 Buckingham Rd. 21207</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1930</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO <i>Melastatic Melanoma Melanoma of the Brain</i> INTERVAL BETWEEN ONSET AND DEATH <i>undetermined</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-19 1967</i> to <i>5-12 1967</i> that (I) (we) last saw the deceased alive on <i>5-12 1967</i> and that death occurred at <i>8:00 AM</i> , from causes and on the date stated above.	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>RUPERT MANANKIL</i>	22d. ADDRESS <i>Baltimore County Gen. Hosp.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/15/67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Meadow Ridge Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Wash. Blvd & Dorsey Rd. Md.</i>
24. FUNERAL DIRECTOR <i>Loring Evers</i>	25a. ADDRESS <i>8728 Liberty Rd. Randallstown, Md.</i>	25b. REC'D BY REGISTRAR <i>MAY 15 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36320

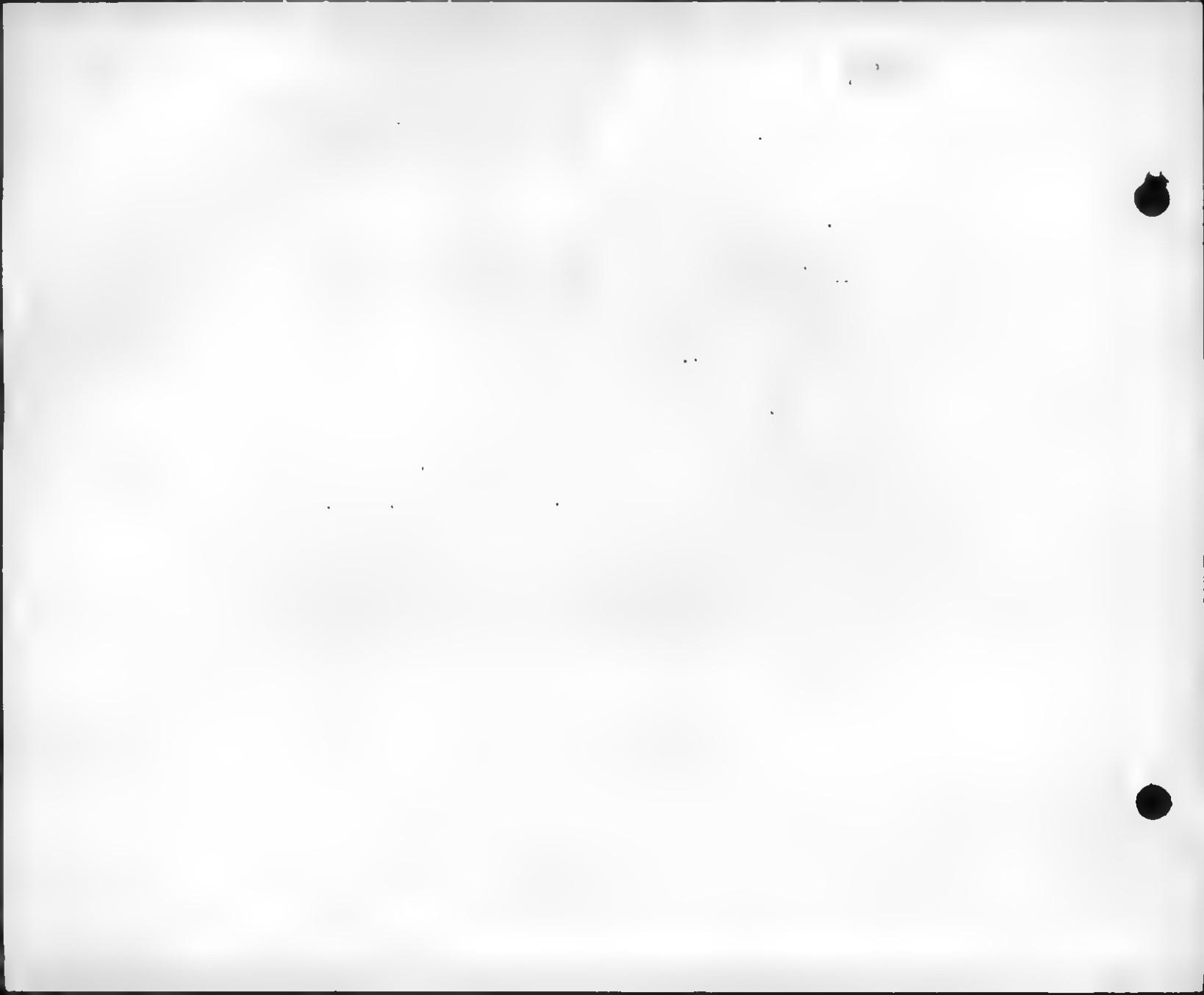
CERTIFICATE OF DEATH

08310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers *Proper time for death*
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1 PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN lb 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 833 W. Lombard St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) ARNOLD		First M	Middle Miller	Last JUSTICE	4 DATE OF DEATH MAY 7 1967	Month MAY	Day 7	Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-12	9 AGE (In years last birthday) 54 yrs	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0 Hours 0 Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Box Factory		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Justice		14. MOTHER'S MAIDEN NAME Emma Ruben County		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 215-10-0916		17. INFORMANT Records, Mount Wilson State Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a) 43411 (b) _____ DUE TO stating the underlying cause last. Pulmonary tuberculosis - ASTHMA (c) _____		INTERVAL BETWEEN ONSET AND DEATH months	
20a. ACCIDENT WAS DUE TO OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pulmonary tuberculosis - ASTHMA		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above		22. SIGNATURE <i>Wm. Newcomer</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 10 1967			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D.		22d. ADDRESS Superintendent Mount Wilson, Maryland		23d. LOCATION (City or Town) Baltimore		(County) Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/67		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		(State)			
24. FUNERAL DIRECTOR Walters Funeral Home Pratt & Fricker Sts		ADDRESS		25a. RECEIVED BY REGISTRAR DATE MAY 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 20 M 1/66									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06321

CERTIFICATE OF DEATH

06321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the funeral.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be retained by the hospital or attending physician. If either, notify medical examiner.

Page 4 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN b d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212		
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 626 Glenwood Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Mary	Middle D	Last KANE	4 DATE OF DEATH Month May	Day Year 6, 1967
5. SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH September 3, 1914	9 AGE (in years, lost birthday) 52 yrs
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME George Dittrich			14. MOTHER'S MAIDEN NAME Anna M. Durrbeck		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 215-10-4942		
17. INFORMANT Family Records			Address		
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hepatic coma					
DUE TO (b) Portal cirrhosis					
DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour: o.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I (this hospital) attended the deceased from March 18, 1967 , to May 6, 1967 , that I (we) last saw the deceased alive on May 6, 1967 , and that death occurred at 1:25 PM , from causes and on the date stated above.					
22a. SIGNATURE Reynaldo Orjuela-Gomez					
22b. DATE SIGNED May 6, 1967					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/10/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS HOLY REDEEMER CEM	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road		25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE Charles J. George	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06322

CERTIFICATE OF DEATH

06312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 9 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS Dogwood Road	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BERNARD	Middle GOODMAN	Last KEIRSEY SR.
4. DATE OF DEATH Month MAY	Month 24	Day 19	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1896
9. AGE (in years last birthday) yrs 70	10. KIND OF BUSINESS OR INDUSTRY Paper Hanging	11. BIRTHPLACE (County & State, or foreign country) Petersburg, Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter H. Keirsey	14. MOTHER'S MAIDEN NAME Mary E. Lucienberg		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. W.W.I 215-22-74-88	17. INFORMANT Clin. Rec. VAH, Fort Howard, Maryland	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH SECONDS	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) THROMBOSIS OF ARTERIOSCLEROTIC CORONARY ARTERY		UNKNOWN	
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) V.A. HOSPITAL, FORT HOWARD, MARYLAND
21. I certify that (he) (this hospital) attended the deceased from May 15, 1967 , to May 24, 1967 , that (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 6:00PM from causes and on the date stated above.			
22a. SIGNATURE <i>Alfonso Lopez</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/24/67
22c. PHYSICIAN'S NAME (Type) ALFONSO LOPEZ, M.D.		22d. ADDRESS V.A. HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery
24. FUNERAL DIRECTOR R.V. SINGLETON FUNERAL HOME GLEN BURNT, MD.		ADDRESS	25a. REC'D. BY REGISTRAR MAY 26 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

W A D

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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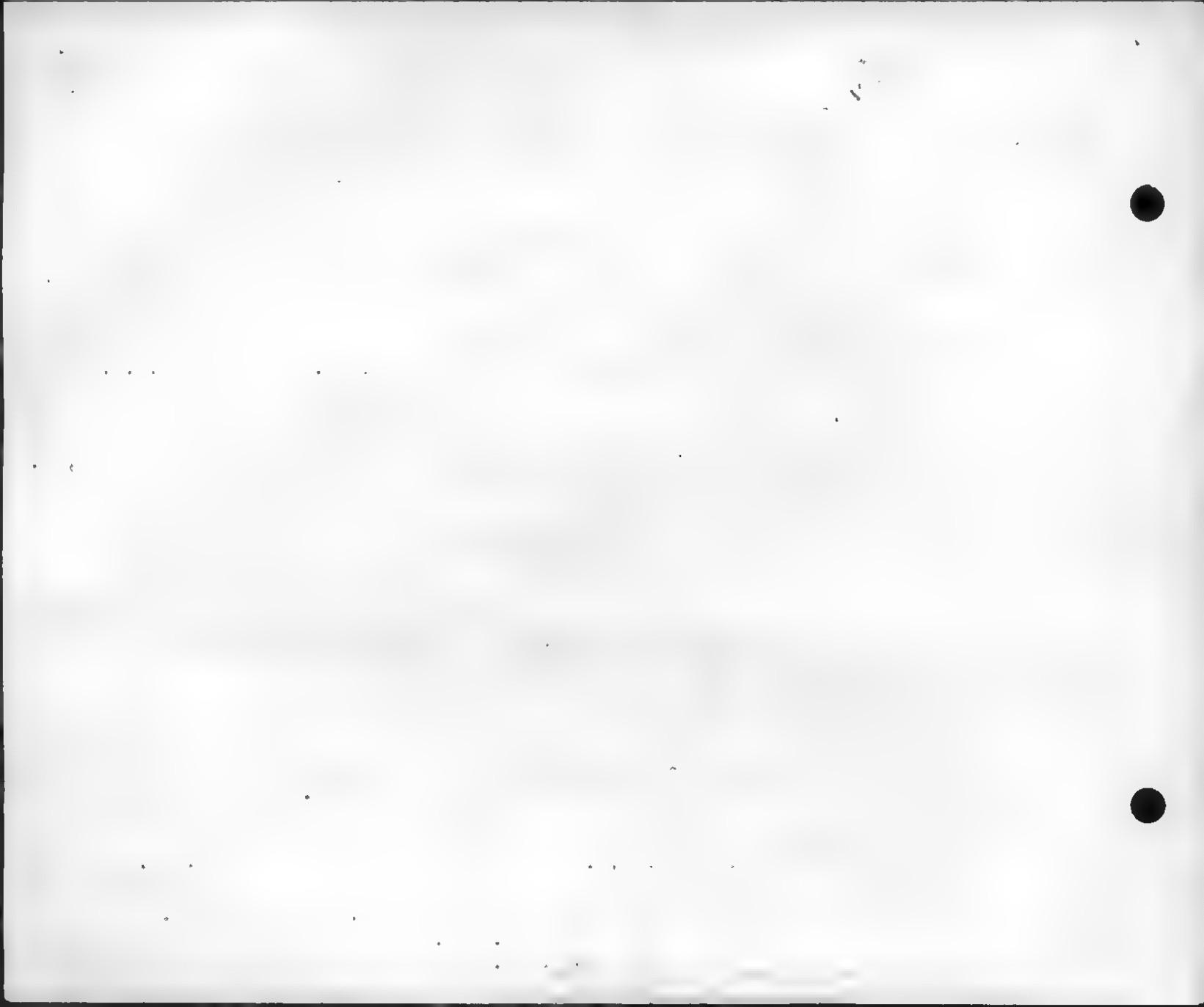
CERTIFICATE OF DEATH

36313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 17		
			d. STREET ADDRESS 2255 Reisterstown Road		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF RELEASED (Type or print)	First CHARLES	Middle BROWN	Last KELLER	4 DATE OF DEATH May 13 1967	Month Day Year
S. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/28/94	9 AGE (in years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Monotype Operator		10b KIND OF BUSINESS OR INDUSTRY Newspapers		11 BIRTHPLACE (County & State, or foreign country) Littleton, Pa.	
13. FATHER'S NAME Charles B. Keller			14. MOTHER'S MAIDEN NAME Lucinda King		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I			16. SOCIAL SECURITY NO. 217 09 42 79		
17. INFORMANT Clinical Rcds VA Hospital, Fort Howard, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH Days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)			Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic vascular Heart Disease-Congestive Heart Failure					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)	
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 4 1967 to May 13 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 13 1967 , and that death occurred at 1:20 PM , from causes and on the date stated above.					
22a SGNATURE <i>Alfonso A. Lopez, Jr.</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/13/67		
22c. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/1967	23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery, Baltimore, Md.	23d. LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR Wm. J. Tickner & Sons Tickner Funeral Home		25a. ADDRESS North & Penna. Ave. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE MAJ 16 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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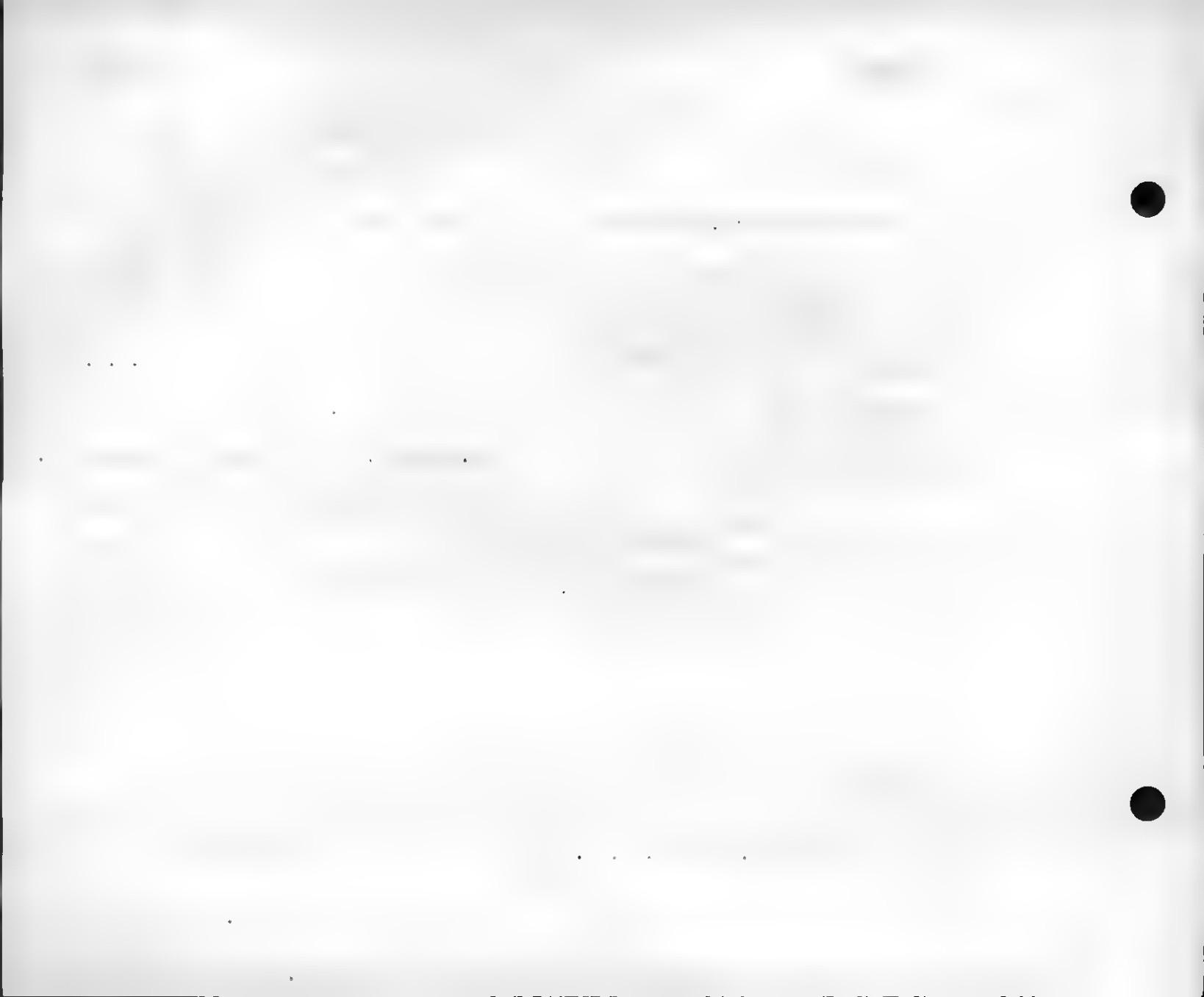
CERTIFICATE OF DEATH

06314

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transmittal permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 78 DAYS		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) d. STATE MARYLAND		e. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) WHITE MARSH		f. COUNTY BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS BOX 1071B								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY C. KELLNER		First	Middle	Last	4. DATE OF DEATH MAY 26 1967	Month	Doy	Year			
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/30/95	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min		
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING SHOP		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME OSCAR KELLNER		14. MOTHER'S MAIDEN NAME MINNIE MN: UNKNOWN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 215 10 66 85		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE PAPILLARY NECROSIS KIDNEYS, BILATERAL						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN					
Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause lost XURXO		(b) PULMONARY EDEMA				RECENT					
		(c) ARTERIOSCLEROTIC HEART DISEASE									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITON GIVEN IN PART I(a) DIABETES MELLITUS, CLINICAL											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJRY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from 3/9/67 , 19, to 5/26/67 , 19, that (X) (we) last saw the deceased alive on 5/26/67 , 19, and that death occurred 6:15 AM , from causes and on the date stated above.											
22a. SIGNATURE <i>Jorge A. Fabara</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 5/26/67					
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-29-67		23c. NAME OF CEMETERY OR CREMATORIUM CAMP CHAPEL CEMETERY		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR LASSAHN FUNERAL HOME		ADDRESS 7401 Belair Road, Baltimore, Md.		25a. REG'D. BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event, ~~remove carbon paper~~, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, ~~remove carbon paper~~.

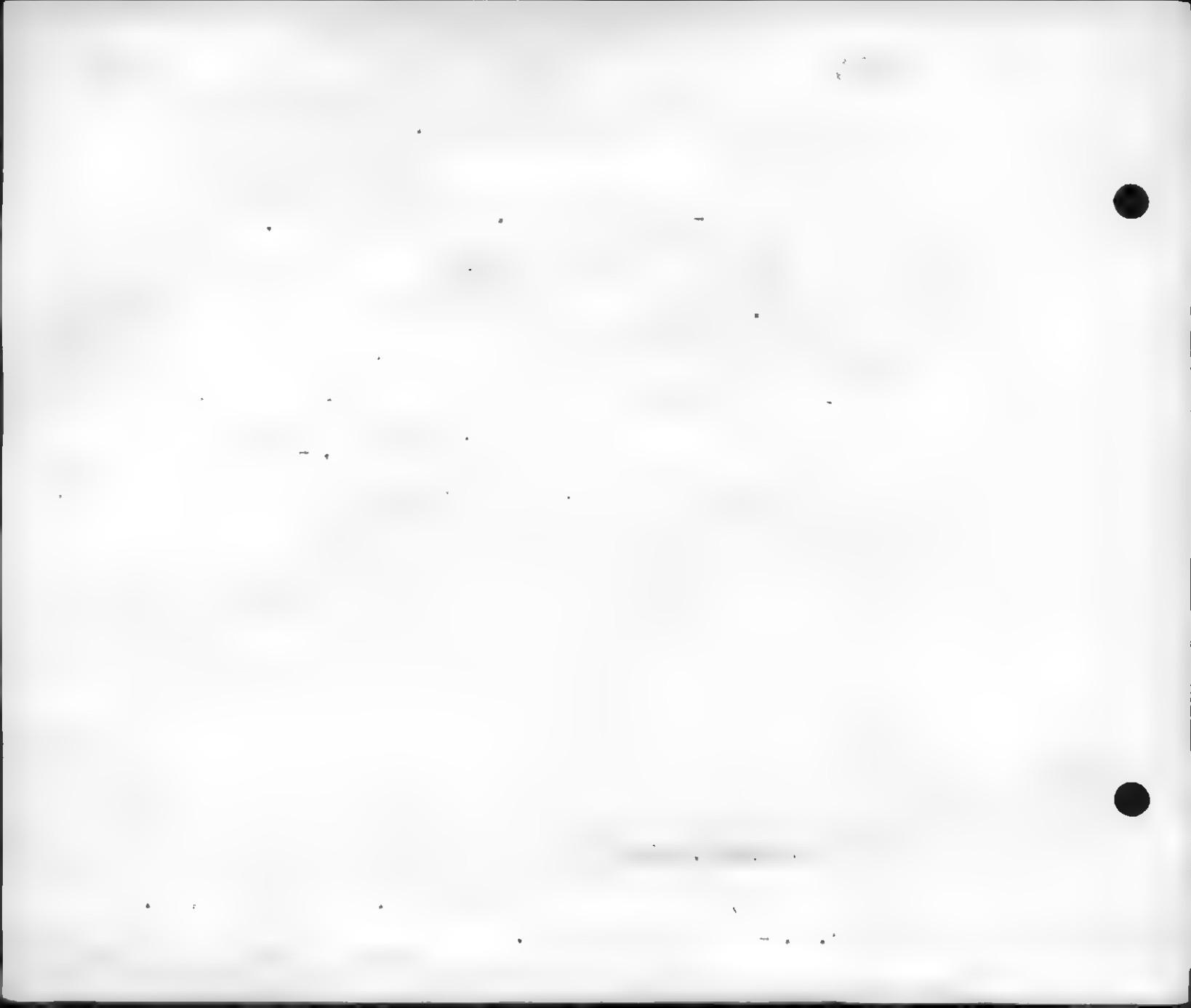
36325

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #2c & d file 23122 6/2/67 pg 2

CERTIFICATE OF DEATH

36315

1. PLACE OF DEATH a. COUNTY Baltimore			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.			b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville Balto. 21221			d. STREET ADDRESS (Summit Nursing Home 609 Stamford Rd 98 Smithwood Ave)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home - 98 Smithwood Ave.													
3. NAME OF DECEASED (Type or print) Anna Marie Kelly			First	Middle	Last	4. DATE OF DEATH May 18			Month	Day	Year	19 67	
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/88			9. AGE (In years last birthday) 79 yrs			F UNDER 1 YEAR Months	F UNDER 24 HRS Days	Hours	Min.
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State or foreign country) New Jersey			12. CITIZEN OF WHAT COUNTRY USA				
13. FATHER'S NAME Late - Joseph McCurnin			14. MOTHER'S MAIDEN NAME Late - Mary										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO			17. INFORMANT Mrs. Marie Kelly Snyder Address 609 Stamford Rd. - 21229							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis with Chronic Brain Syndrome									INTERVAL BETWEEN ONSET AND DEATH 1 yr.				
444X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Essential Hypertension									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19													
21. I certify that (I) (the hospital) attended the deceased from Oct. 19 51 to May 19 67 , that (I) (we) last saw the deceased alive on May 16 19 67 , and that death occurred at 10 PM , from causes and on the date stated above													
22a. SIGNATURE <i>J. J. Gaver</i>			MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS						22b. DATE SIGNED May 19, 1967				
22c. PHYSICIAN'S NAME (Type) J. J. Gaver, M.D.			22d. ADDRESS 1 Mallow Hill Road										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/22/67			23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery			23d. LOCATION (City or Town) Baltimore, Md.			(County)	(State)
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.			ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 22 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

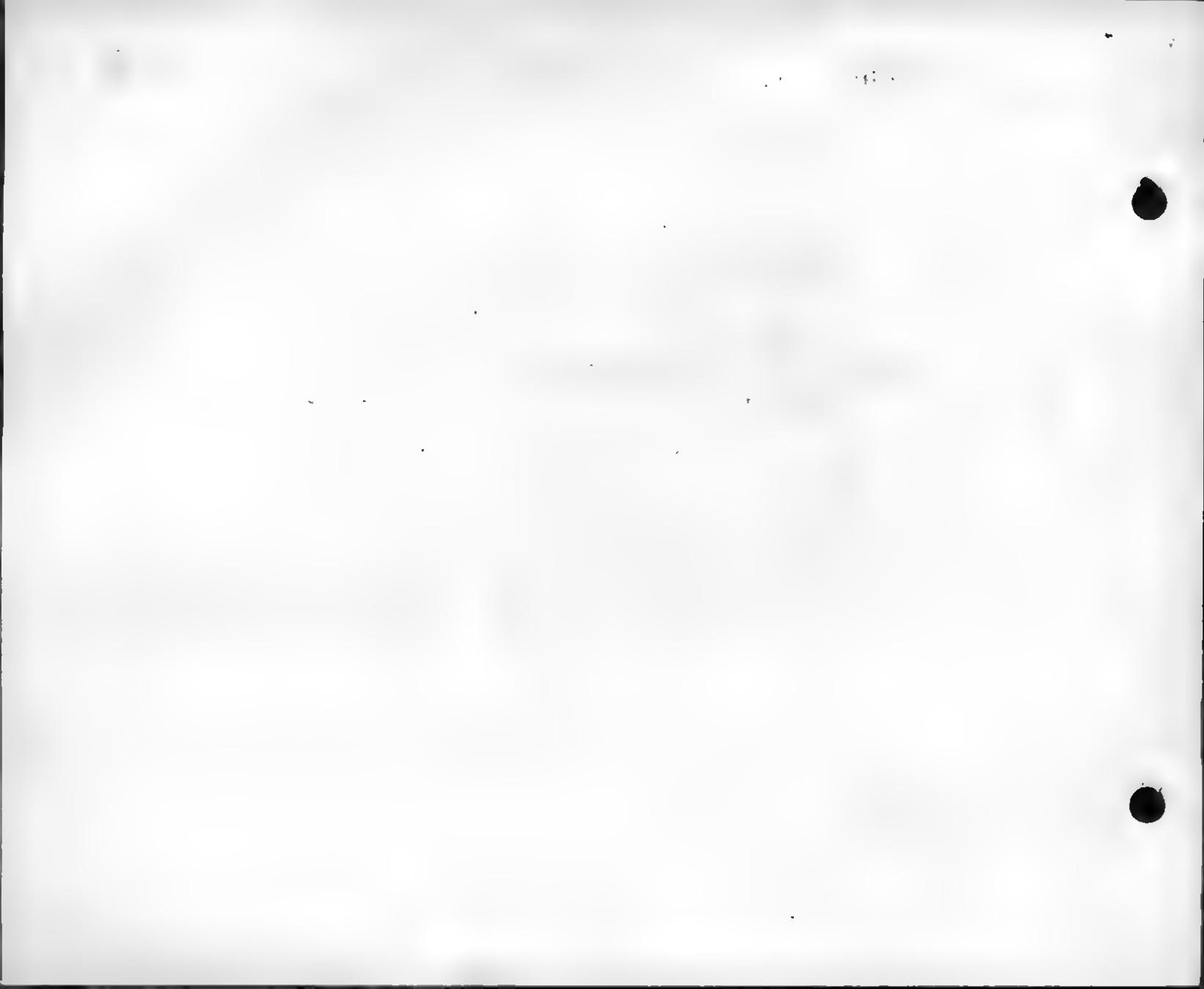
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 film 6239 5/26/67 lk

CERTIFICATE OF DEATH

06316

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN lb 50 yr.		c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) Parkville							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3009 6th Ave.			d. STREET ADDRESS 3009 6th Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First HOWARD	Middle E	Last KEMMERLY	4. DATE OF DEATH May 22	Month May	Day 22	Year 1967				
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 15 1885	9. AGE (in years last birthday) 81 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Balto Transit		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Lazarus Kemmerly			14. MOTHER'S MAIDEN NAME Esther Ford			Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-2995		17. INFORMANT Family Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterioscler CVD e Myocard infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) and (c) Chronic myopathy				INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8th Street		20f. (City or town) Baltimore		(County) Md.		(State) MD	
21. I certify that (I) (this hospital) attended the deceased from 6 AM , 19 67 , to 22 May , 19 67 that (I) (we) last saw the deceased alive on 19 May , 19 67 , and that death occurred at 19 May , 19 67 M, fram causes and on the date stated above.											
22a. SIGNATURE Howard Goodman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 23 May 67			
22c. PHYSICIAN'S NAME (Type) Howard Goodman		22d. ADDRESS 8604 Harford road									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/67		23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park		23d. LOCATION (City or Town) Baltimore		(County) Md.		(State) MD	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford Rd.		ADDRESS		25a. REC'D. BY REGISTRAR MAY 24 1967		25b. REGISTRAR'S SIGNATURE J. Evans Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36327

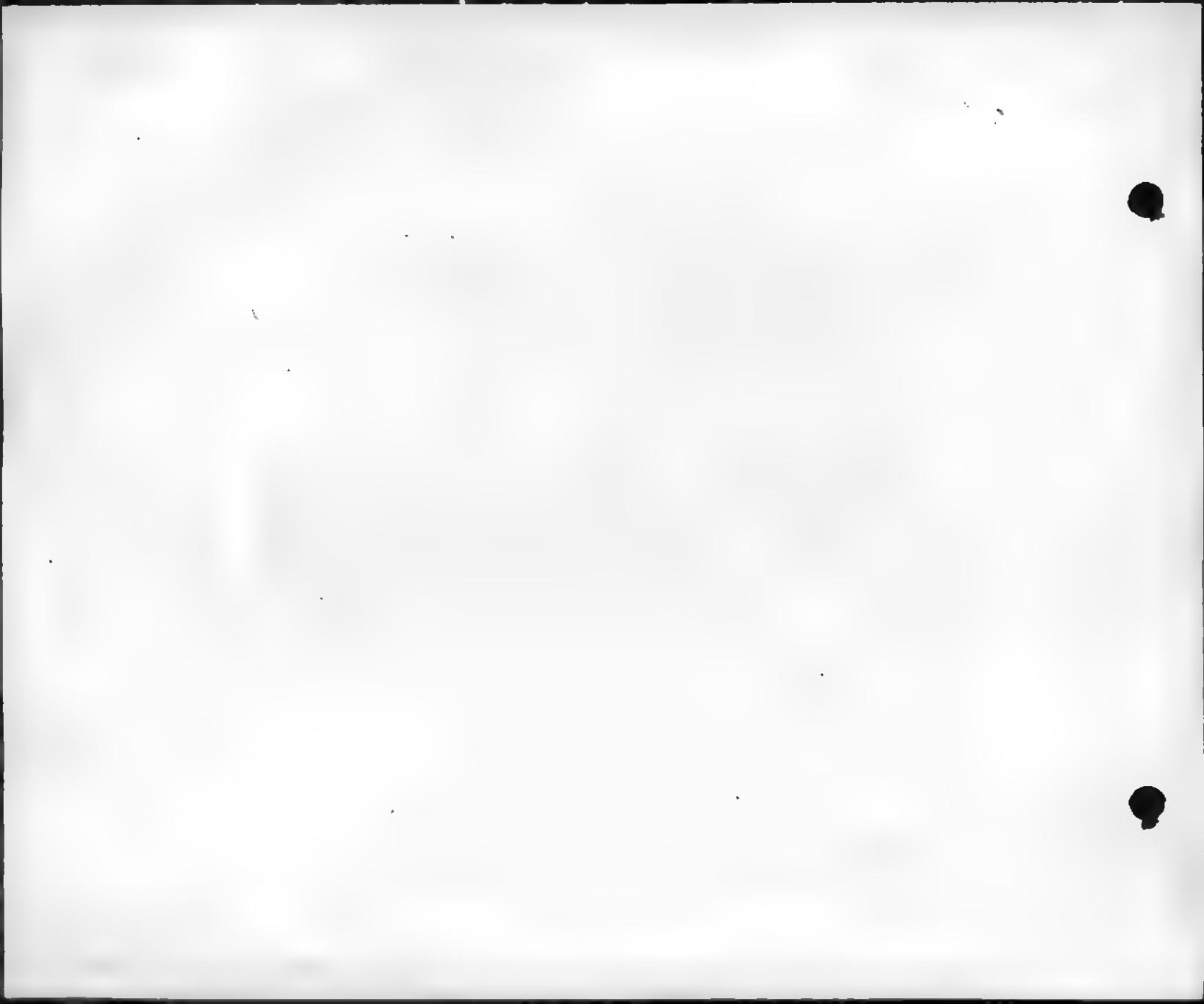
CERTIFICATE OF DEATH

08217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fork</i>	c. LENGTH OF STAY IN 1b <i>25 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fork Md</i>	d. STREET ADDRESS <i>Box 38 Fork Rd Baldwin</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Box 38 Fork Rd Baldwin</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Julia</i>	First <i>J</i>	Middle <i>L</i>	Last <i>Kendrick</i>
4. DATE OF DEATH <i>5 4 1967</i>	Month <i>5</i>	Doy <i>4</i>	Year <i>1967</i>
5. SEX <i>W</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-24-1898</i>
9. AGE (In years last birthday) <i>76 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	12. BIRTHPLACE (County & State, or foreign country) <i>Hungary</i>
13. FATHER'S NAME <i>John Peterawak</i>	14. MOTHER'S MAIDEN NAME <i>Mary Demasco</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO <i>None</i>	17. INFORMANT <i>MR George Thy At 38 Baldwin Ind</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>334 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>General arteriosclerosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>12 mo</i>		
(b) DUE TO <i>Congestive heart failure</i>	10 yr.		
(c) DUE TO <i>Diabetes mellitus</i>	2 yr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8/24 1965</i> to <i>5/4 1967</i> , that (I) (we) last saw the deceased alive on <i>8/31 1964</i> , and that death occurred at <i>Fork</i> M.D., from causes and on the date stated above	22b. DATE SIGNED		
22c. SIGNATURE <i>Clifford F. Hudson</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON</i>	22d. ADDRESS <i>Fork MD.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5-6-1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore Anne Arundel Md</i>
24. FUNERAL DIRECTOR <i>LaSahn Funeral Home 7400 Belair Road</i>	ADDRESS <i>(30)</i>	25a. REC'D BY REGISTRAR <i>Patricia Ann Attwells</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
DATE <i>MAY 8 1967</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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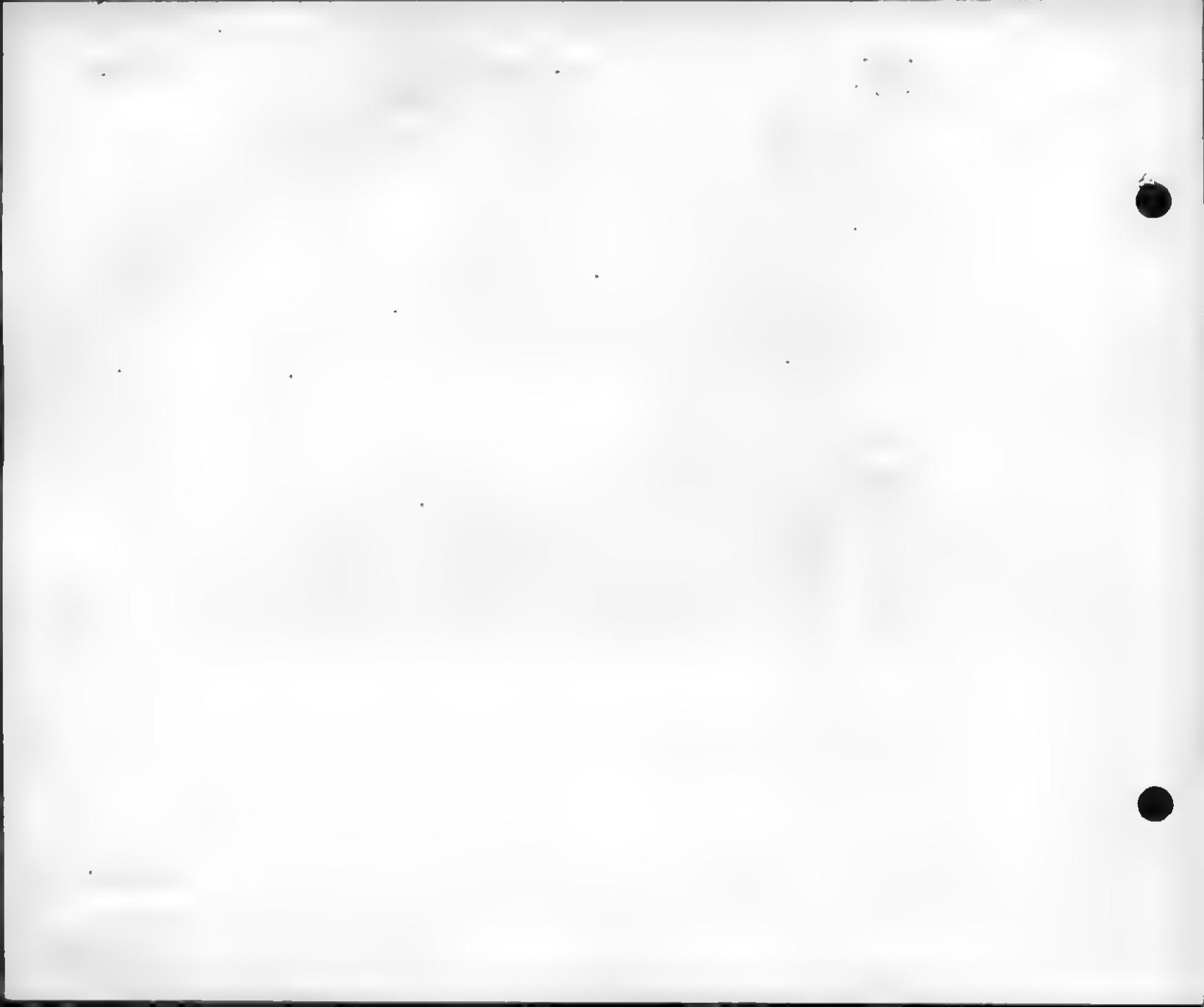
CERTIFICATE OF DEATH

08218

10 HOSPITAL ATTENDING PHYSICIAN: This form may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON	c. LENGTH OF STAY IN b. 1 week	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	d. DATE OF DEATH May 15, 1967
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hilton	First B.	Middle King	Month May Doy 15 Year 1967
4. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> X NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-10
9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of work no. of hours even if retired) receiving dept.	10b. KIND OF BUSINESS OR INDUSTRY Food	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Crosse & Blackwell		
14. MOTHER'S MAIDEN NAME Mrs. Eleanor King	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		
16. SOCIAL SECURITY NO. 212-09-7523	17. INFORMANT Address 21221 Mrs. Eleanor King, 608 North Woodward Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm			INTERVAL BETWEEN ONSET AND DEATH
+ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) DUE TO 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 15, 1967 to May 15, 1967 , that (I) (we) last saw the deceased alive on May 15, 1967 , and that death occurred at 10:50 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Juan Gan</i>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED May 15, 1967
22c. PHYSICIAN'S NAME (Type) Juan Gan M.D.	22d. ADDRESS 7620 York Road - Towson 21204, Md.		
23a. BURIAL CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 5-18-67	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park	23d. LOCATION (City or Town) (County) (State) Baltimore County, Md.
24. FUNERAL DIRECTOR Ulrich Funeral Home, Baltimore, Md.	ADDRESS	25a. REGISTRATION NUMBER MAY 22 1967	25b. REGISTRAR'S SIGNATURE <i>James J. Ulrich</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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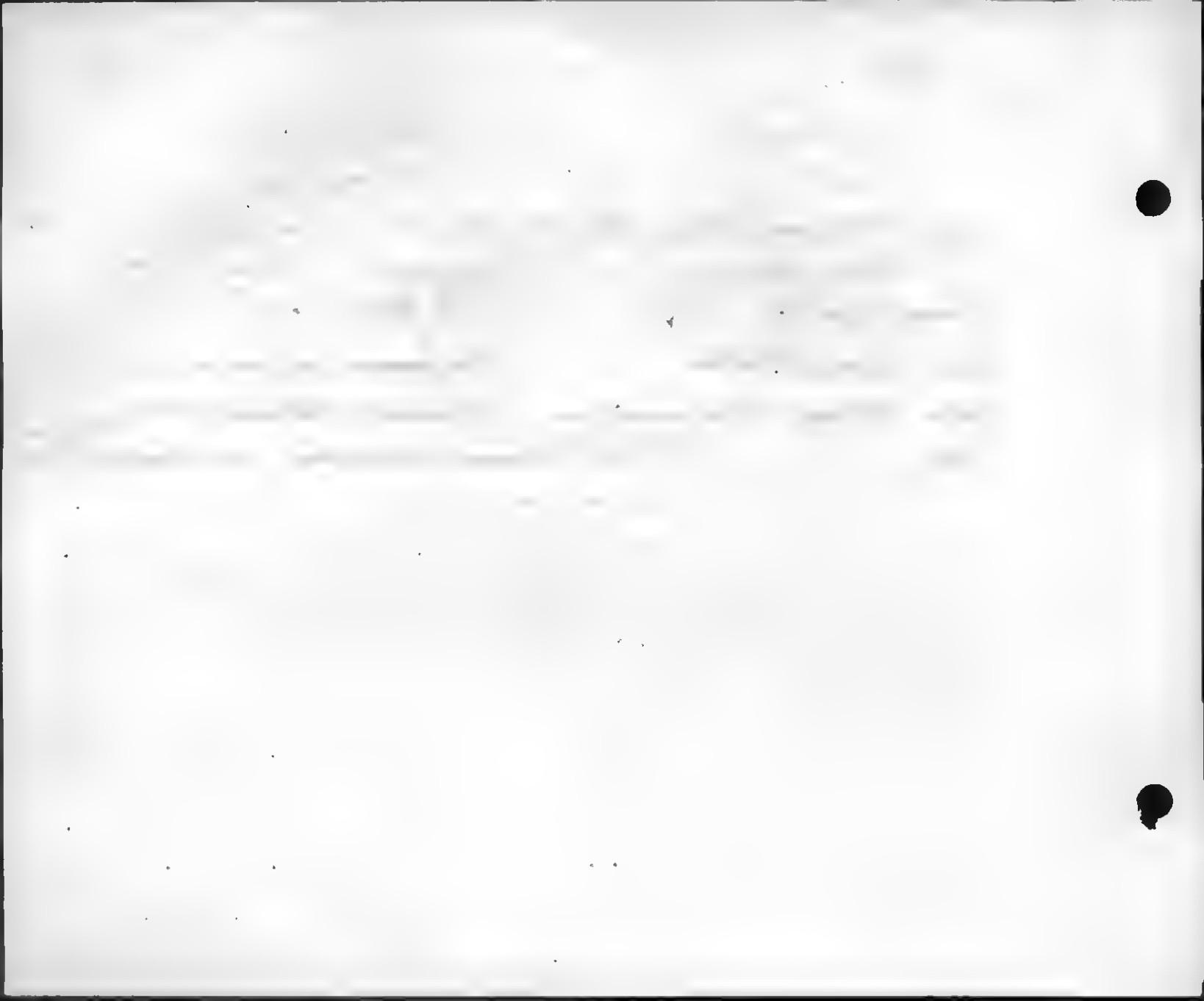
CERTIFICATE OF DEATH

65219

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN lb <u>5 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Agee Women's & Men's Home</u>		d. STREET ADDRESS <u>619 E. 33rd Street</u>	
3 NAME OF DECEASED (Type or print) <u>Mrs Louise Saunders</u>		First <u>Kjellberg</u>	Last <u>May</u>
S. SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <u>1892</u>		9. AGE (In years last birthday) <u>79 yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most at working life even retired) <u>Dept. of Motor Vehicles</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, Virginia</u></u>	
13. FATHER'S NAME <u>John Henry Bramberry</u>		12. CITIZEN OF WHAT COUNTRY? <u>El. S. A.</u>	
14. MOTHER'S MAIDEN NAME <u>Adelaide Gouldmane</u>		15. INTERVAL BETWEEN ONSET AND DEATH <u>15 M.</u>	
16. SOCIAL SECURITY NO. <u>213-18-7793</u>		17. INFORMANT <u>Dairy E. Hammett, 615 Chestnut Ave.</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4342</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute cardiac failure (terminal)</u> DUE TO (c) <u>Acute pulmonary edema, bilateral</u>		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATE ON ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Chronic arteriosclerotic, cardio-vascular syndrome</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 14, 1962</u> , to <u>May 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1967</u> , and that death occurred at <u>4:45 A.M.</u> , from causes and on the date stated above.		20f. (City or town) <u>Towson</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
22a. SIGNATURE <u>Edwin B. Jarrett</u>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <u>Edwin B. Jarrett, M.D.</u>		22d. ADDRESS <u>11 East Chase St., City-2.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>May 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Green Mount Crematory</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Rd., 21204</u>		25a. RECEIVED BY REGISTRAR DATE <u>MAY 22 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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06330

CERTIFICATE OF DEATH

08320

10 HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb BALTIMORE DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 1308 WOODBURN AV			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EDGAR		First	Middle	Last	4. DATE OF DEATH KNAUFF SR.	Month 5	Day 10	Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 11, 1891	9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 24 HRS Months 0	YEAR Days 0	IF UNDER 24 HRS Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Bldg. Inspector			10b. KIND OF BUSINESS OR INDUSTRY Housing Auth.		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE BALT. Md. USA			12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William G. Knauff			14. MOTHER'S MAIDEN NAME Nannie McIlvain						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 215-05-2625		17. INFORMANT HUGH KNAUFF		Address 1357 NORTHERN PKWY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Ganglionic Arteriosclerosis</i> DUE TO (c) <i>Diabetes Mellitus</i>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Parkville	(County) Baltimore Co.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from left , 1964, to May 10, 1967 , that (I) (we) last saw the deceased alive on 4/20 1967 , and that death occurred at 11 AM , from causes and on the date stated above									
22a. SIGNATURE <i>Richard Frael</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 6/10/67				
22c. PHYSICIAN'S NAME (Type) C. Richard Frael			22d. ADDRESS Medical Arts Bldg., Baltimore, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parkwood 4905 York Rd.		23d. LOCATION (City or Town) Parkville, Baltimore Co., Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR MAY 12 1967		25b. REGISTRAR'S SIGNATURE Richard Judge			
VR A15 (4) 25M 1/67									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

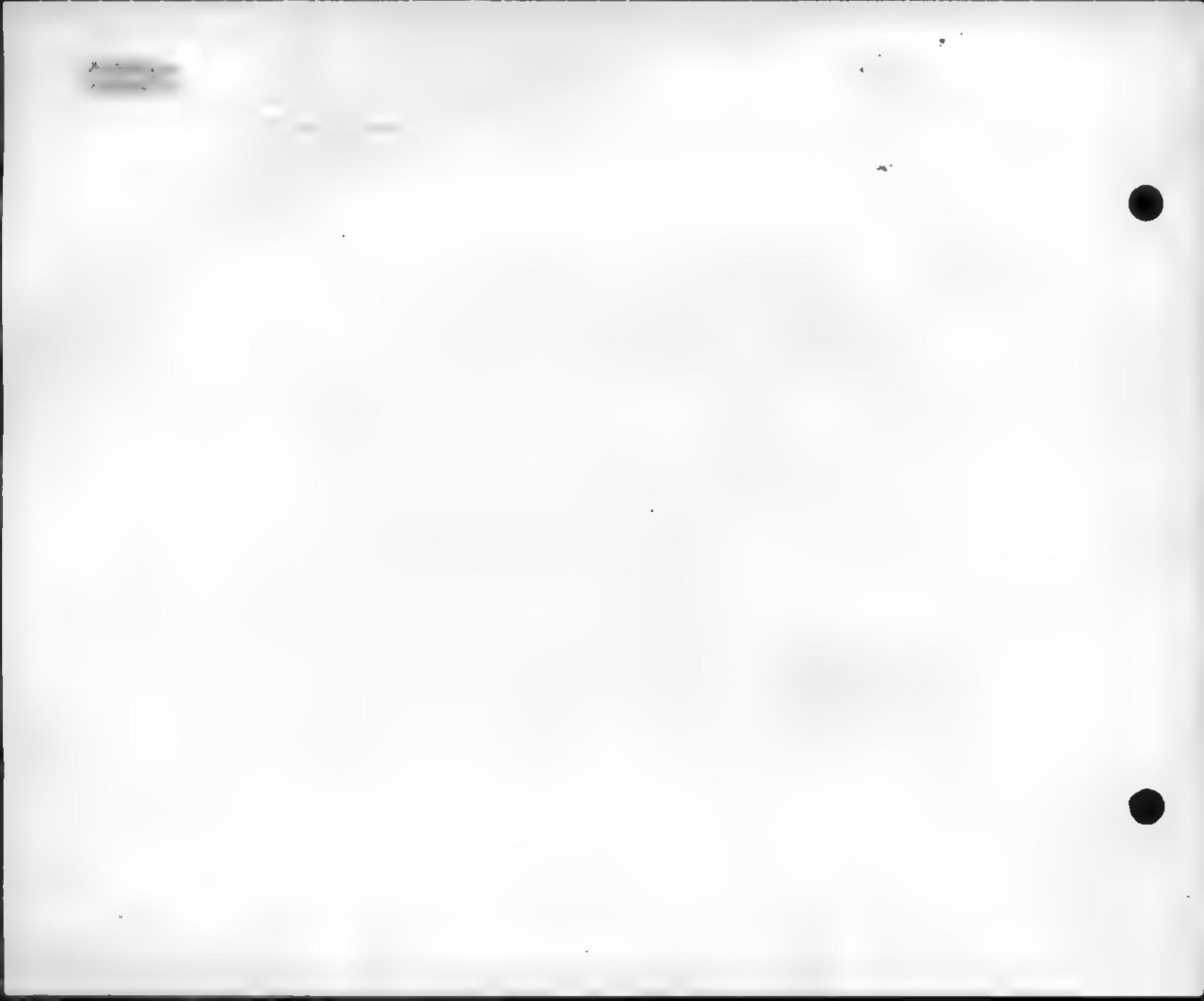
06331

CERTIFICATE OF DEATH

06331

HOSPITAL ATTENDANT: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in one event, within 72 hours of her death.

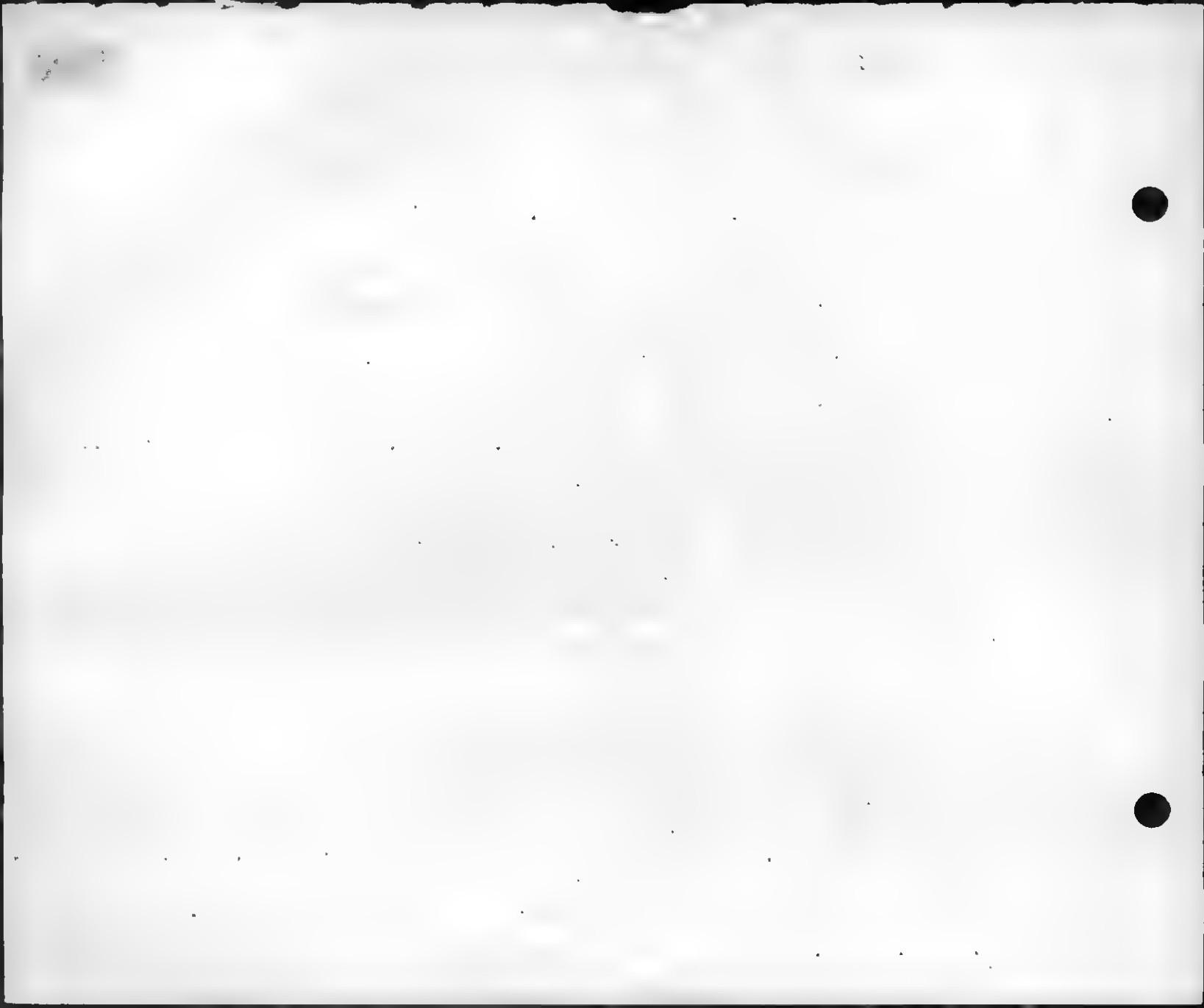
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b. BALTIMORE		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY	
				5 days							
3. NAME OF DECEASED (Type or print)		First WALTER	Middle PHILLIP	Last KRAETER.	4. DATE OF DEATH MAY 1st 1967		Month MAY	Day 1st	Year 1967	5. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX MALE.		7. COLOR OR RACE WHITE	8. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. DATE OF BIRTH 12-28-01	10. AGE (In years lost birthday) 65 yrs	11. IF UNDER 1 YEAR Months	12. IF UNDER 24 HRS Days	13. IF UNDER 24 HRS Hours	14. IF UNDER 24 HRS Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN.		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME PHILLIP KRAETER.		14. MOTHER'S MAIDEN NAME KOFFOLOPPE		15. ADDRESS							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		17. SOCIAL SECURITY NO. 220-30-1568		18. INFORMANT PPs HISTORY.							
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) stating the underlying cause last		Acute Myocardial Infarction		20. INTERVAL BETWEEN ONSET AND DEATH 4 days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4. 27. 1967, to 5. 1. 1967, that (I) (we) last saw the deceased alive on 5. 1. 1967, and that death occurred at 12-45A M, from causes and on the date stated above.						22b. DATE SIGNED 5. 1. 67.					
22c. PHYSICIAN'S NAME (Type) Dr L SERRA M. USHA KUMARI				22d. ADDRESS L701. NORTH CHARLES STREET - BALTIMORE, MARYLAND							
23a. BURIAL CREMATION, REMOVAL (Society) Burial		23b. DATE THEREOF 5/4/67		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery		23d. LOCATION (City or Town) Baltimore, Md. (County) (State)					
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		ADDRESS		25d. RECEIVED BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE jCharles Judge					
VR A15 (4) 25M 1/67											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

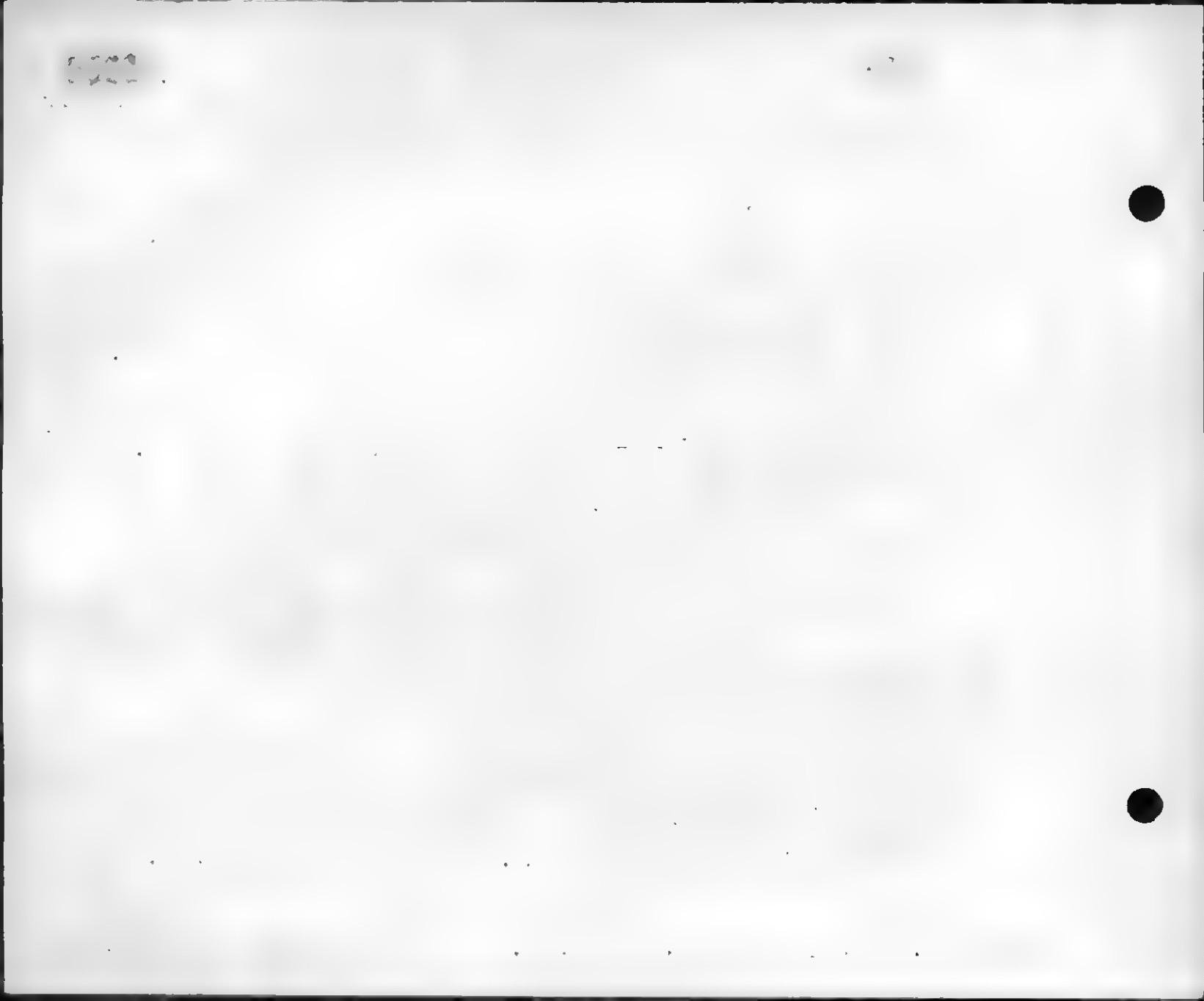
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #8 Film #57867 Date 5/15/67											
1. PLACE OF DEATH a. COUNTY Baltimore			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Summit Nursing Home, 98 Smithwood Ave.						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City			d. STREET ADDRESS 93 Bali Road		
3. NAME OF DECEASED (Type or print) Dora			First Dora			Last Krantz			4. DATE OF DEATH Month May Day 8 Year 1967		
5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1984 May 20, 1986/ 82 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Work in Bakery			10b. KIND OF BUSINESS OR INDUSTRY Bakery			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Late Frederick Schmelz						14. MOTHER'S MAIDEN NAME Margaret					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 214-10-0490A			17. INFORMANT Mr. Frank M. Krantz, 107 McAlpine Rd., Ellicott City			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						CORONARY THROMBOSIS, ACUTE			3 MINUTES		
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b)			MYOCARDIAL INFARCTION, RECENT			5 WEEKS		
			DUE TO (c)			ARTERIOSCLEROSIS			10 YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 5/15/67 to 5/18/67 that (I) (we) last saw the deceased alive on 5/15/67, and that death occurred at 7:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Paul R. Ziegler</i>									22b. DATE/SIGNED 5/18/67		
22c. PHYSICIAN'S NAME (Type) Paul R. Ziegler						22d. ADDRESS 200 Chestnut Hill Dr., Ellicott City, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 11, 1967			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Loudon Park			23d. LOCATION (City, town or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Harry H. Witzke, 321 Columbia Pike, Ellicott City Maryland						25a. REC'D BY REGISTRAR DATE MAY 9 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please sign and initial the signature line. Director, page 3 should be detached for use as the burial/transit permit. Then please sign and initial the signature line. Director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												36333	36323						
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				b. STATE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Baltimore MARYLAND				Maryland Baltimore				Maryland				Dundalk							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1B 4 Months				d. STREET ADDRESS 1835 Portship Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1835 Portship Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. DATE OF DEATH May 2 1967											
3. NAME OF DECEASED (Type or print)		First Mabel		Middle May		Last Krantz		4. DATE OF DEATH May		Month		Day		Year					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/24/98		9. AGE (in years last birthday) 68 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Deys Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Louis Lanham				14. MOTHER'S MAIDEN NAME Ida Belle Wright				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-30-4334				17. INFORMANT (Son) Melvin Krantz, 7124 Crestshire Rd. Dundalk, Maryland 21222			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH 5 months							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1150 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)												Adeno carcinoma of abdominal cavity Severely metastatic, probably originated from ovaries							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (This hospital) attended the deceased from July 15, 1965, to May 2, 1967, that (I) (We) last saw the deceased alive on April 28, 1967, and that death occurred at 4:15 P.M. from the causes and on the date stated above.								22c. PHYSICIAN'S NAME (Type) Attaollah Golpira				22d. ADDRESS M.D. 1942 Cedar Lane, Dundalk, Md. 21222		22e. DATE SIGNED 5/2/67					
22c. PHYSICIAN'S NAME (Type) Attaollah Golpira								23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/5/67		23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR				ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md. 21222				25a. REC'D BY REGISTRAR MAY 4 1967				25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 (4) 15M 4-64																			



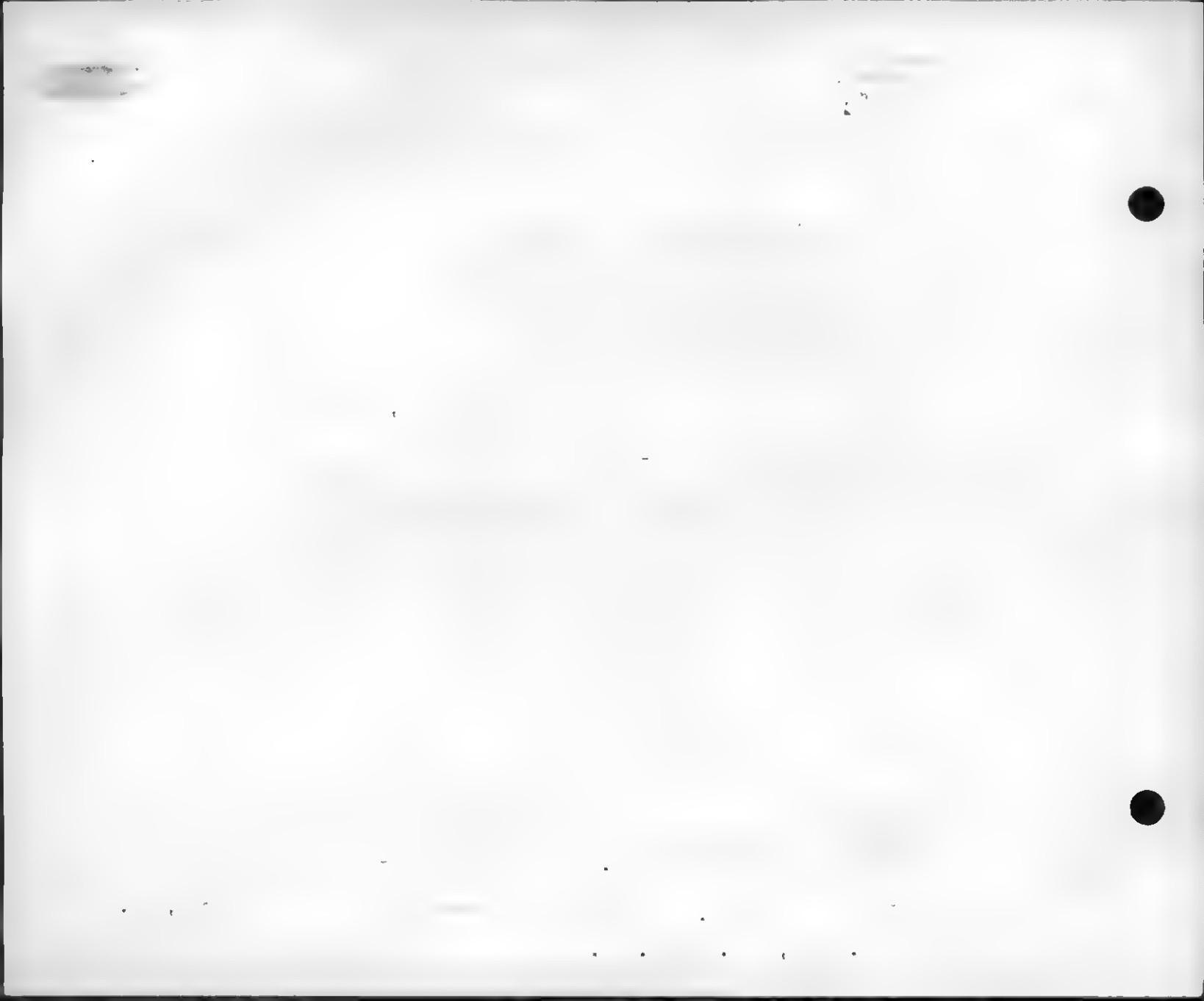
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06334

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Towson			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER			d. STREET ADDRESS 1655 Argonne Drive		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Harrietta N.M.N.	First	Middle	Last Kress	4. DATE OF DEATH May 24 1967	Month Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1884	9. AGE (in years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13. FATHER'S NAME William Simmons			14. MOTHER'S MAIDEN NAME Price, Harrietta		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-30-4984		17. INFORMANT Mr. Richard Simmons	Address Same as patient
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND. T.O.N. G.VEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/8/1967 to 5/24/1967 , that (I) (we) last saw the deceased alive on 5/24/1967 , and that death occurred at 2:55pm , from causes and on the date stated above.					
22a. SIGNATURE <i>John E. Adams</i>		M.D.	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) John E. Adams, M. D.		22d. ADDRESS Greater Baltimore Medical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/67.		23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balt. Md. 21214		ADDRESS		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
VR A15 (4) 25M 1/67		25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 2
36335

CERTIFICATE OF DEATH

36335

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 1 month		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 8219 Belair Road		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JAMES	Middle A.	Last KROLL	4. DATE OF DEATH May 30, 1967
S. SEX. Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 1, 1894	9. AGE (in years last birthday) 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME ?				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO 212-14-8489		17. INFORMANT Address Dagmar Ritzman, Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterial coronary thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH Instant	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>arteriosclerosis heart dis.</i>		DUE TO (b) <i>last</i>		5 years	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6801 BELAIR Rd	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Sept 10, 1960 to 5-30, 1967 that (I) (we) last saw the deceased alive on 5-4, 1967 , and that death occurred at 3:15 AM , from causes and on the date stated above.					
22a. SIGNATURE <i>Wm. Wong</i>		22b. DATE SIGNED 6-1-67			
22c. PHYSICIAN'S NAME (Type) Wm. Wong		22d. ADDRESS 6801 BELAIR Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 3, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Wiesburg Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore Maryland					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	
				25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 25M 1/67		DATE JUN 5 1967			

17.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

6
96336

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6326

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before illness, etc.) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN MD 4 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9716 Tulsemere Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown	
f. STREET ADDRESS 9716 Tulsemere Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle LEE	Last KRUSENKLUS
4. DATE OF DEATH Month May	Month May	Day 19,	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/31
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Gen Elec Supply	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Krusenklaus		14. MOTHER'S MAIDEN NAME Helen Carr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO 400-38-1755	
17. INFORMANT Betty Jo Krusenklaus		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head	
		DUE TO 116 X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in head	
20c. TIME OF INJURY Month, Day, Year about 10:00 pm 5-19 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Baltimore	
(County) Md.		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Springate</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 20, 1967	
Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/23/67	23c. NAME OF CEMETERY OR CREMATORIAL Calvary	23d. LOCATION (City or Town) Louisville
24. FUNERAL DIRECTOR Young Byers		ADDRESS 8728 Liberty Rd Randallstown Md	25a. RECEIVED BY REGISTRAR Charles Judge
		DATE MAY 22 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

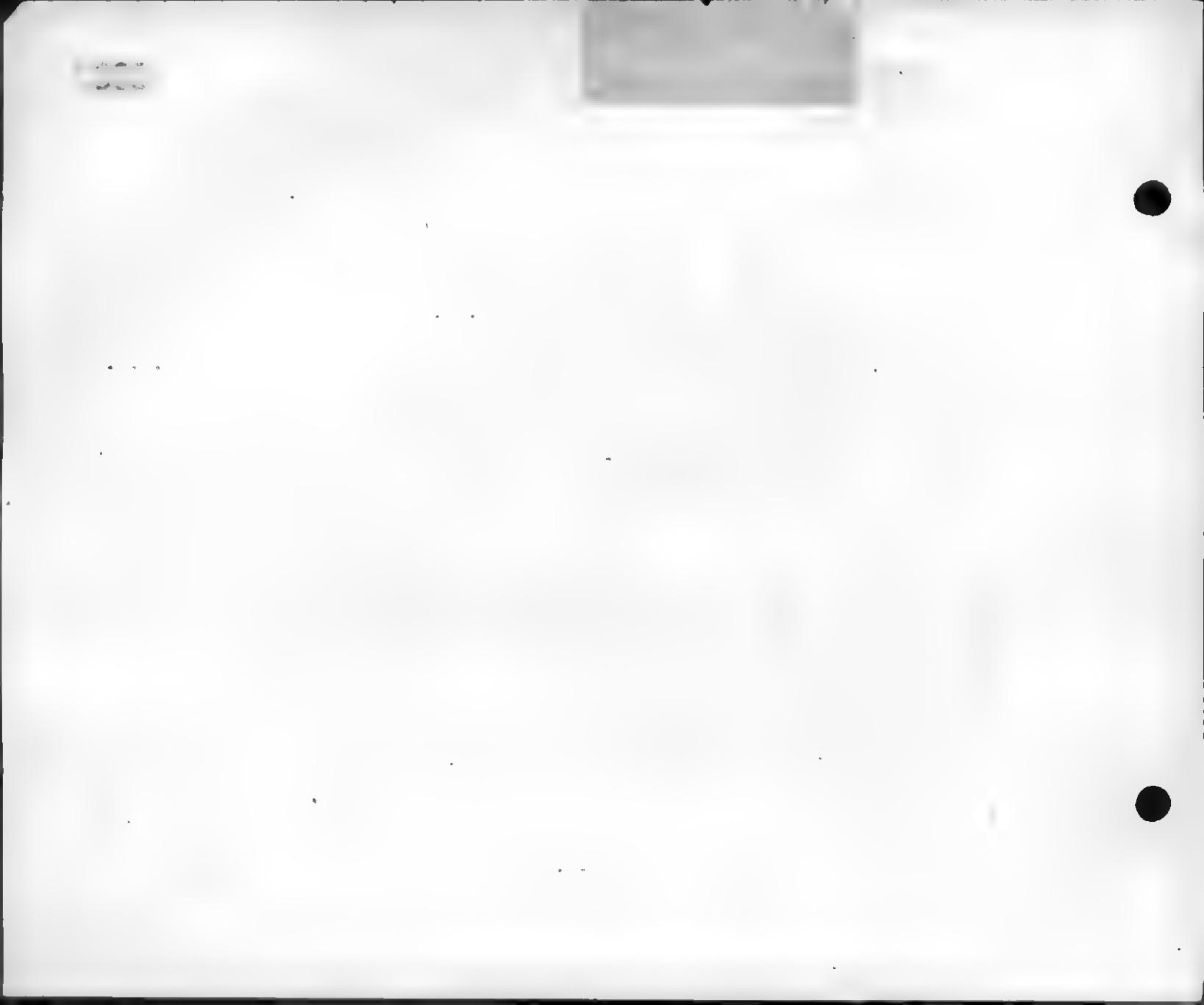
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06337

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 27yr3mth7days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. STREET ADDRESS 1229 Glyndon Street	
f. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First Mary	Middle Kusslis
4. DATE OF DEATH May 16	Month May	Day 16	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 30, 1891		9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months 0
10a. JOURNAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Taylor shop	11. BIRTHPLACE (County & State, or foreign country) Lithuania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Maichael Kaiser	
14. MOTHER'S MAIDEN NAME Antoinette Sherpenskas		15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO 215-05-8037		17. INFORMANT Address Records: Spring Grove State Hospital	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)		INTERVAL BETWEEN ONSET AND DEATH 6 to 8 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from Feb. 9, 1939 to May 16, 1967 , that (1) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 3:55 P.M. from causes and on the date stated above.		22b. DATE SIGNED 5-17-67	
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>		ATTENDING M.D. <input type="checkbox"/>	P. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/20/67	23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery
24. FUNERAL DIRECTOR John J. Corrigan Funeral Home		25a. REC'D BY REGISTRAR DATE MAY 18 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
ADDRESS 101 Belair Rd. E3, Md.			



HOSPITAL OR ATTENDING PHYSICAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

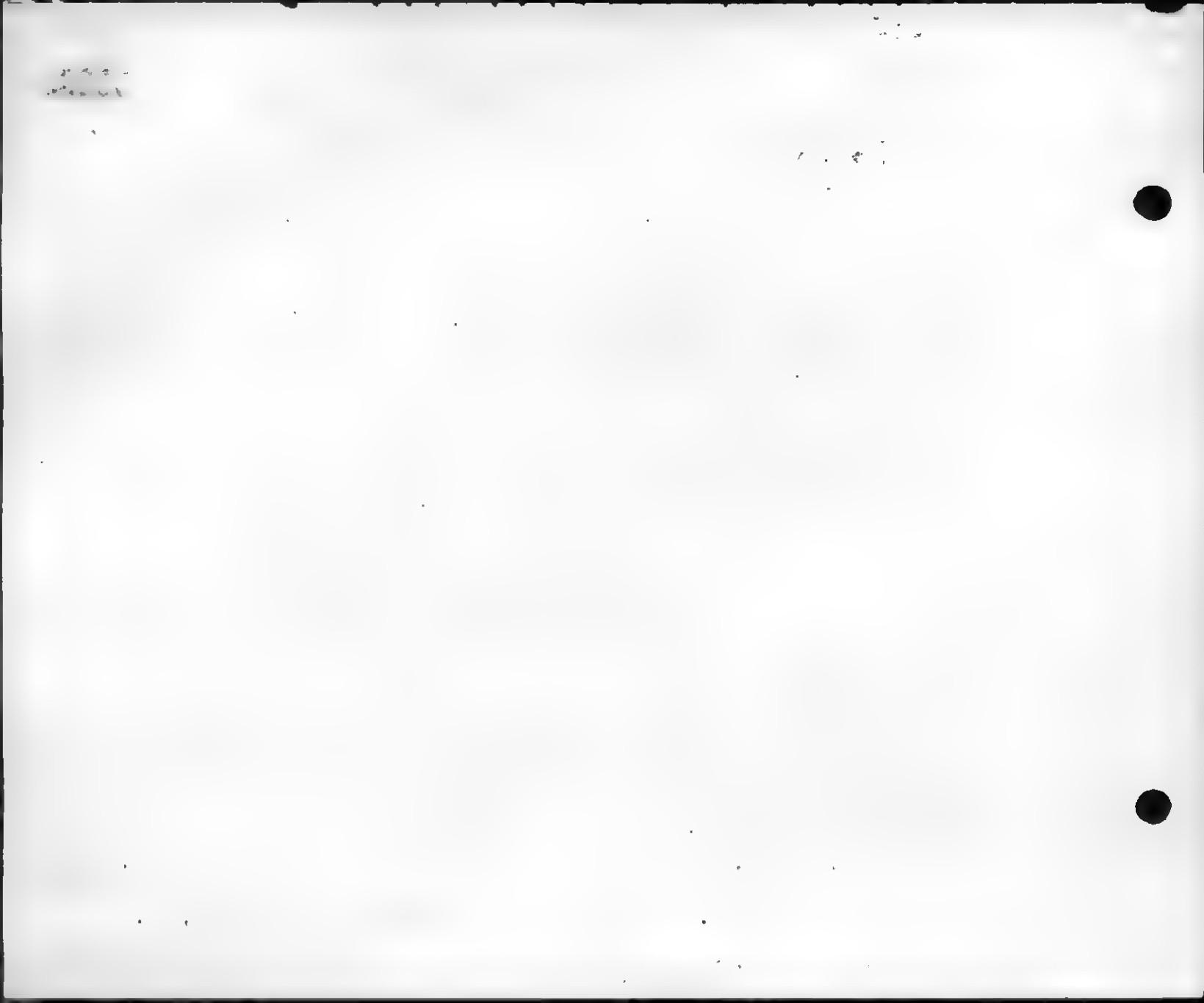
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06338

CERTIFICATE OF DEATH

06328

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Baltimore City		c. LENGTH OF STAY IN b 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Baltimore City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 221 Bowleys Quarters Road			d. STREET ADDRESS 221 Bowleys Quarters Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANTHONY		First Middle L	Lost AGNA	4. DATE OF DEATH May 8 1967	Month May	Day 8	Year 1967
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH Jan. 17, 1888	9. AGE (In years last birthday) 79 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret'd) cement finisher, retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ?		Lagna		14. MOTHER'S MAIDEN NAME Dominica ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-01-2010		17. INFORMANT Mrs. Pose Martin--221 Bowleys Quarters Rd.-20			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) <i>Metastasis To Liver</i> DUE TO stating the underlying cause last. (c)							
INTERVAL BETWEEN ONSET AND DEATH year 1967							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1964, to May 8, 1967, that (I) (we) last saw the deceased alive on May 8, 1967, and that death occurred at 8 AM, from causes and on the date stated above.							
22a. SIGNATURE <i>John V. Ashworth</i>		M.O. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/9/67		
22c. PHYSICIAN'S NAME (Type) Dr. John V. Ashworth		22d. ADDRESS 1129 St. Paul St., Balt., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/12/67.	23c. NAME OF CEMETERY OR CREMATORIUM Gardens of Faith Cemetery	23d. LOCATION (City or Town) Baltimore, Md.			(County) (State)
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Baltimore, Md.--14		ADDRESS		25a. REC'D BY REGISTRAR MAY 10 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 20 M 1/68		DATE					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36333

CERTIFICATE OF DEATH

DE329

TO HOSPITAL OR ATTENDING PHYSICIAN: This death certificate must be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		d. STREET ADDRESS 2409 Annapolis Rd. 21230					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Mynard	Middle E.	Last Lake	4. DATE OF DEATH May 28 1967	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/85	9. AGE (In years at birthday) 82 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Financial Secretary		10b. KIND OF BUSINESS OR INDUSTRY IUOE		11. BIRTHPLACE (County & State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin Lake		14. MOTHER'S MAIDEN NAME Catherine Maney					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-10-6176		17. INFORMANT Mrs. Dorothy M. Orem		Address 21230 2409 Annapolis Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic cardiovascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 months +</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) { DUE TO last. (c)}							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March 28, 1967, to May 25, 1967</i> , that (I) (we) last saw the deceased alive on <i>May 28, 1967</i> , and that death occurred at <i>10 P.M.</i> from causes and on the date stated above.							
22a. SIGNATURE <i>John A. Nesbitt Jr.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5-31-67</i>			
22c. PHYSICIAN'S NAME (Type) John A. Nesbitt Jr.		22d. ADDRESS 1009 Frederick Road					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/67		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR JUN 2 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 25M 1/67							



FOR STATE
HEALTH DEPT.

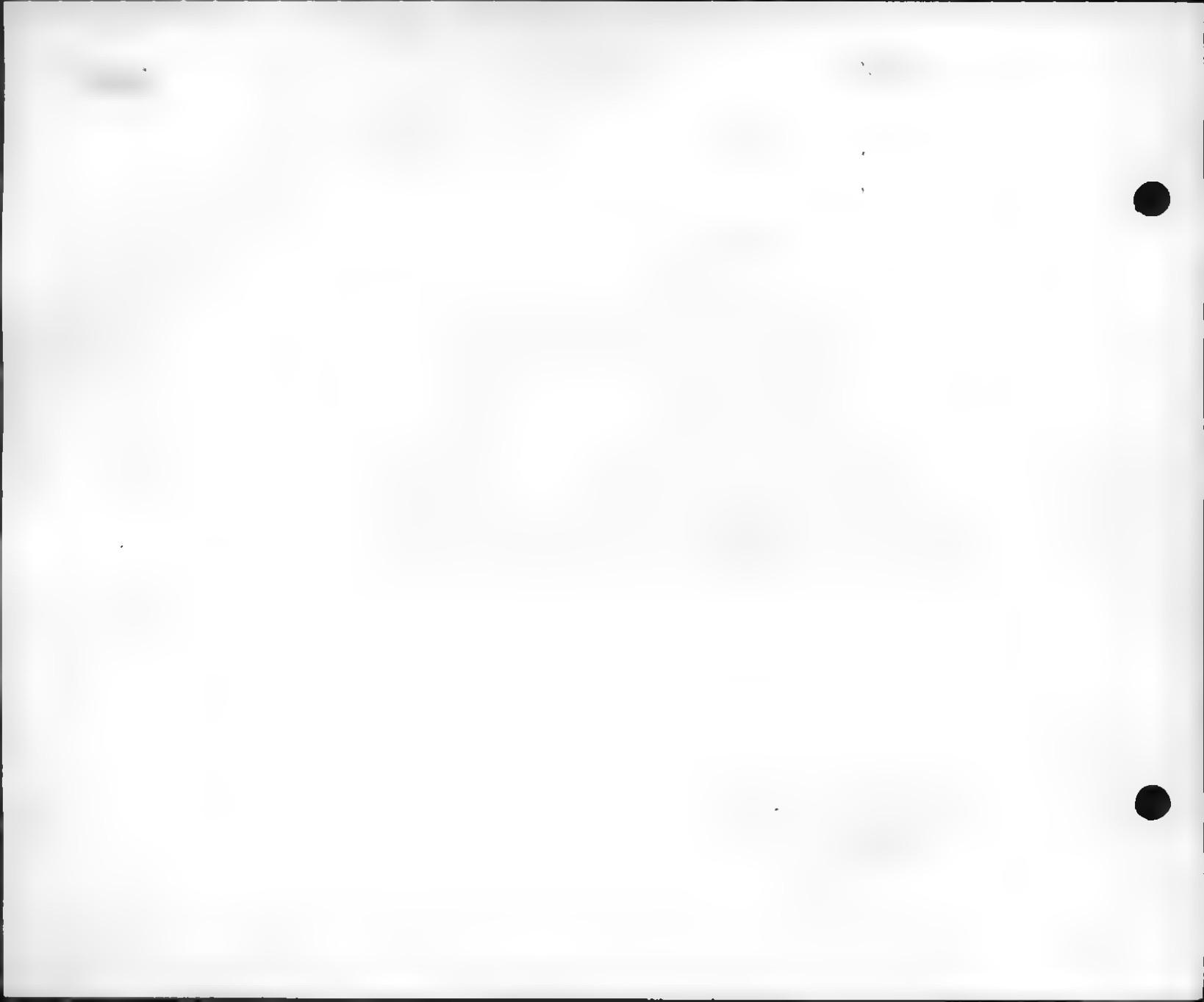
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05330

1 PLACE OF DEATH a COUNTY Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland		b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) 7245 Holabird		d STREET ADDRESS 7245 Holabird Ave		e S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) William R. Lane		First	Middle	Last	4 DATE OF DEATH May 6 /67	Month	Day Year 19
5 SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input type="checkbox"/> widow	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 16 1914	9 AGE (in years last birthday) 52 yrs	10 IF UNDER 1 YEAR Months <input type="checkbox"/>	11 IF UNDER 24 HRS Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Steel		10b KIND OF BUSINESS OR INDUSTRY Beth Steel		11 BIRTHPLACE (State or foreign country) Penna.		12 CITIZEN OF WHAT COUNTRY? Nell O Toole	
13 FATHER'S NAME William Lane		14 MOTHER'S MAIDEN NAME Terry P Lane		17 INFORMANT 7245 Holabird Ave		Address	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		18		INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201		DUE TO (b) Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost		Cokoray Occlusion Hypertension C-V Disease			
DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED Home		20c NATURE OF INJURY IN Part I or Part II of Item 1B Not White at work		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20e INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20f PLACE OF INJURY Home farm factory, street, office bldg., etc Not at work		20g CITY, TOWN, COUNTY, STATE	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Melvin B Davis		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5/16/67	
EXAMINER'S NAME (Type) Melvin B Davis 6800 Mornington Road				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify) removal		23b DATE THEREOF May 6/67		23c NAME OF CEMETERY OR CREMATORY St. Johns Cem.		23d CITY, TOWN, COUNTY, STATE Scottsdale Pa	
24 FUNERAL DIRECTOR Ulrich Funeral Home 2112 Dundalk Ave Dundalk		ADDRESS		25a REC'D BY REC'D BY Clarence Judge		25b DATE MAY 11 1967	
6M 1/67							

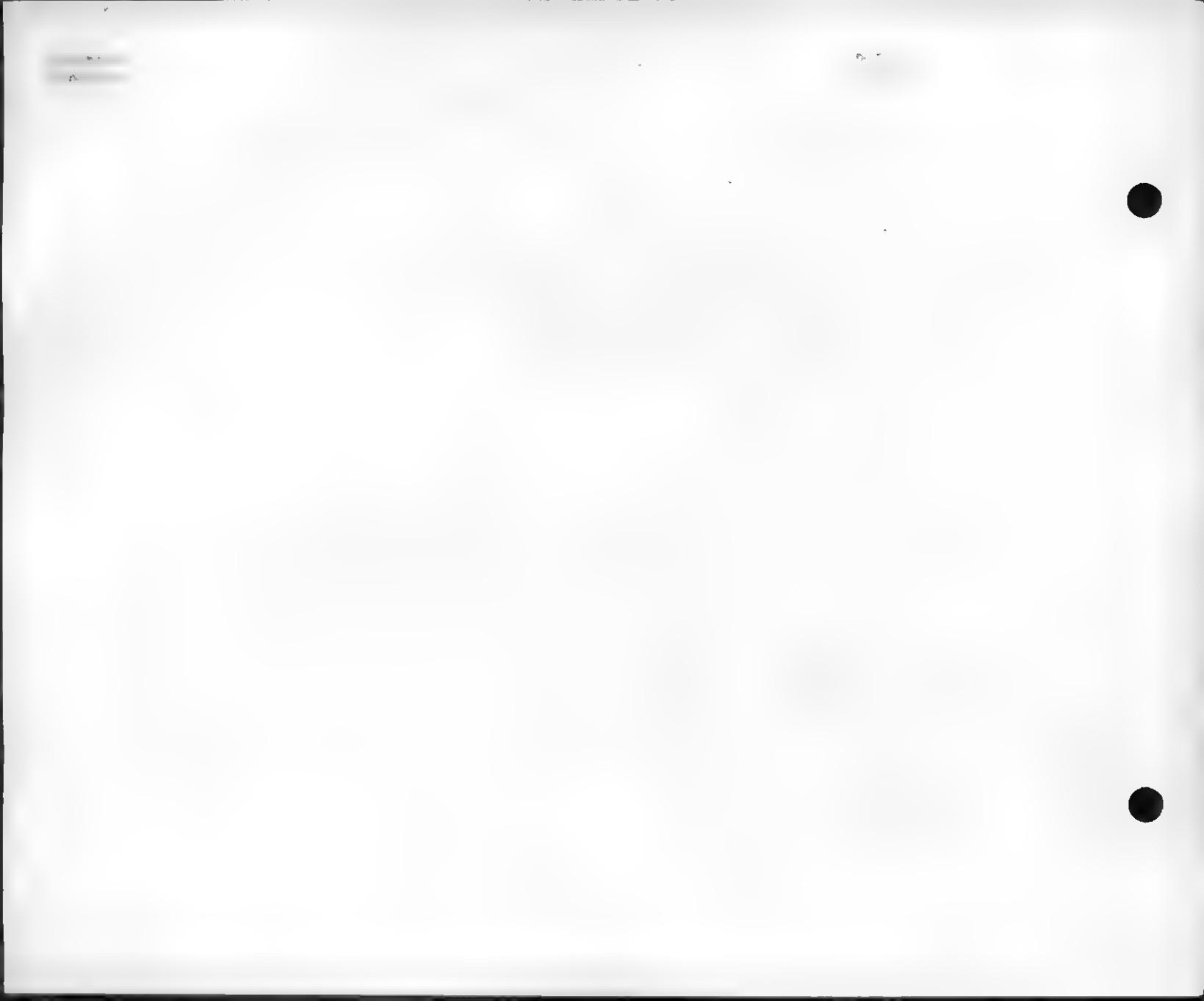


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06341		CERTIFICATE OF DEATH						56331								
1 PLACE OF DEATH a. COUNTY BALTO			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CALONSVILLE			c. LENGTH OF STAY IN lb			b. COUNTRY BALTO										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 NEWBURG AVE			d. STREET ADDRESS 11 NEWBURG AVE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3 NAME OF DECEASED (Type or print) CATHERINE O. LANG		First	Middle	Last	4 DATE OF DEATH	Month	Day	Year								
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/81	9. AGE (In years last birthday) 85 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min								
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Md.										
13. FATHER'S NAME JOHN INGALLS		14. MOTHER'S MAIDEN NAME ALVERDIA JOHNSON														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO			17. INFORMANT		Address									
MRS T. ALLAN Muir																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4500 Dehydration DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Chronic arteriosclerosis - Silver DUE TO (c) Chronic cardiac failure									INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)														
20c TIME OF INJURY Month, Day, Year Hour a.m. pm 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June		20f (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from causes and on the date stated above.									22b. DATE SIGNED 18 May 67							
22a. SIGNATURE William J. Ferguson		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22d. ADDRESS			22b. DATE SIGNED 18 May 67								
22c. PHYSICIAN'S NAME (Type) E.S. McNABIS		23a. BURIAL, CREMATION, REMOVAL (Specify) 5/19/67							23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS WESTERN			23d. LOCATION (City or Town) (County) (State) BALTO, MD.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR MAY 29 1967							25b. REGISTRAR'S SIGNATURE Charles J. Ferguson							
F.S. McNABIS 301 FREDERICK RD 21228																



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06342

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		Maryland Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Lynns Mill Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Greater Baltimore Medical Center		Lynns Mill Road		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (First Middle Last)		Mary Elizabeth Lathe		Lathe		4. DATE OF DEATH		Month Day Year	
5. SEX		6. COLOR OR RACE		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs	
7		Caucasian		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED		5/21/1889		78 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
10a. None		10b. No		11. Baltimore, Md		12. U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Charles Lathe		Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
15. No		16. 513-03-9181		17. Patient Chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Antherosclerotic Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) Congestive Heart Failure							
DUE TO		(c) Acute myocardial infarction							
DUE TO									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 10th, 1967, to May 12th, 1967, that (I) (we) last saw the deceased alive on May 12th, 1967, and that death occurred at 9:30 AM, from causes and on the date stated above									
22a. SIGNATURE Dr. Isabelle MacGregor		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-12-67					
22c. PHYSICIAN'S NAME (Type) Dr. Isabelle MacGregor		22d. ADDRESS Glen Haven Medical Center							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Burial May 15 1967		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Haven Cemetery		23d. LOCATION (City or Town) Brooksville, Md.			
24. FUNERAL DIRECTOR		ADDRESS Frank H. Powell, Oakwood, Md.		25a. FILED BY REGISTRAR DATE MAY 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06343

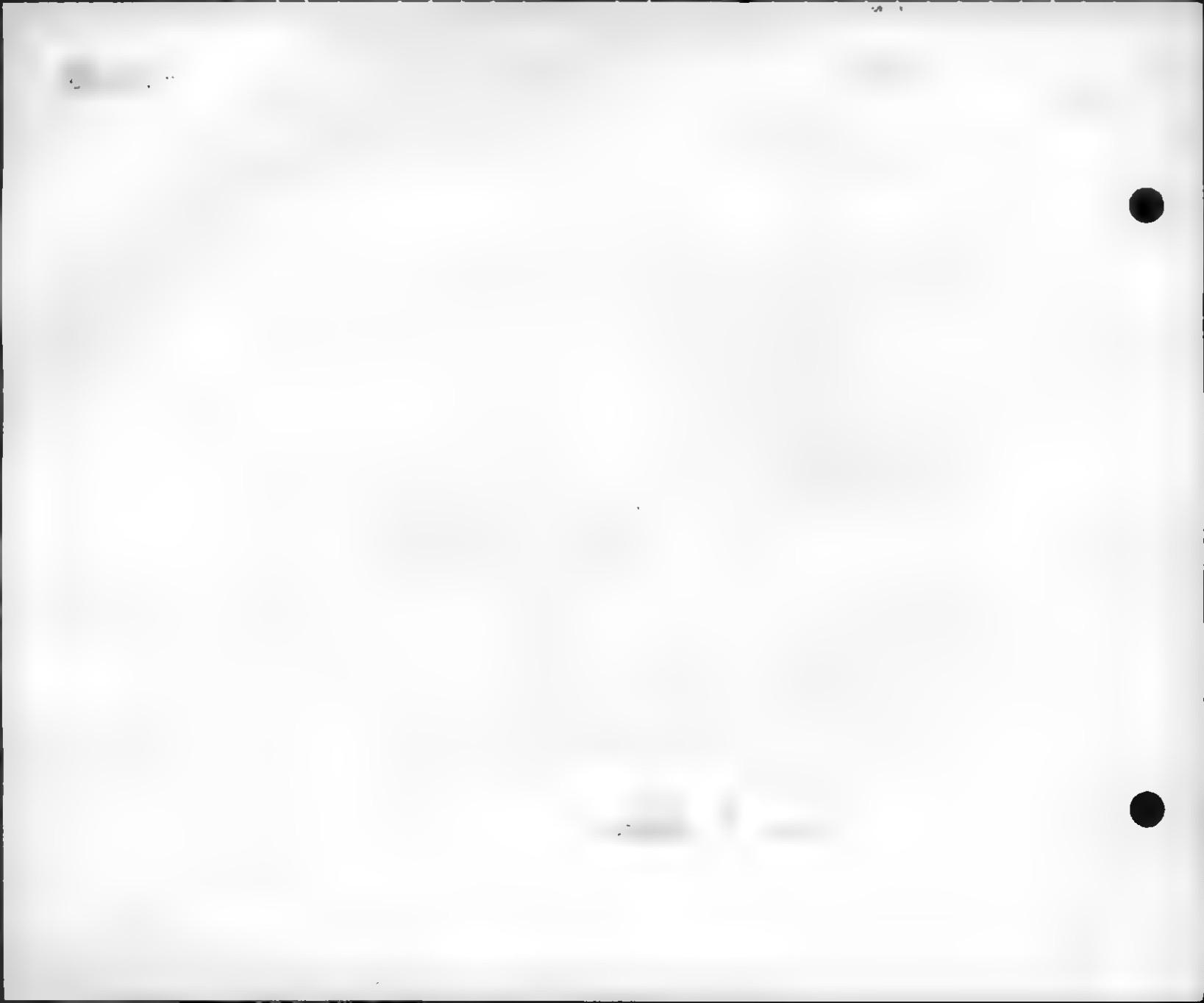
SC333

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: This instrument requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	c LENGTH OF STAY IN lb 20 Days	c CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Baltimore, Maryland 21221	d STREET ADDRESS 294 Stillwater Road
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET	First MARGARET	Middle 	Last LEBRUN
4. DATE OF DEATH May 11 1967	Month May	Day 11	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NEVER MARRIED	8. DATE OF BIRTH 7/16/07
9. AGE (In years last birthday) 59 yrs		10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (County & State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Henry Fred Komber	
14. MOTHER'S MAIDEN NAME Beckhold		15. SOCIAL SECURITY NO 	
16. INFORMANT Patient's History		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction		INTERVAL BETWEEN ONSET AND DEATH 	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		5 Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 22, 1967 to May 11, 1967 , that (I) (we) last saw the deceased alive on May 11, 1967 , and that death occurred at 2:00 AM , from causes and on the date stated above.		22a. SIGNATURE <i>John E. Adams,</i>	
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.		22b. DATE SIGNED 5/11/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/67	23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith
23d. LOCATION (City or Town) (County) (State) Baltimore		23e. REGISTRAR'S SIGNATURE J. Charles Judge	
24. FUNERAL DIRECTOR J. J. Connally Son		25a. REC'D. BY REGISTRAR 300 more	25b. REGISTRAR'S SIGNATURE MAY 15 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

36344 06334

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1B 2yr2mth28dys		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Ethel	Middle NHN	Last Leigh	4. DATE OF DEATH May 8 1967	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1898	9. AGE (in years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.	
13. FATHER'S NAME Charles Hines			14. MOTHER'S MAIDEN NAME Anna Lehay		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 578-05-2575B		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)			DUE TO Arteriosclerotic cardiovascular disease		
			DUE TO Arteriosclerosis, Generalized, senile		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension; Left cerebral hemorrhage (2 yrs. ago).			INTERVAL BETWEEN ONSET AND DEATH 2 years		
20a. ACCIDENT WAS UNDERRYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that OK (this hospital) attended the deceased from Feb. 10, 1965 , to May 8, 1967 , that OK (we) last saw the deceased alive on May 8, 1967 , and that death occurred at OK M, from the causes and on the date stated above.			22b. DATE SIGNED 5-8-67		
22a. SIGNATURE 			22c. ATTENDING M.D. PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-11-67			23b. DATE THEREOF 5-11-67 23c. NAME OF CEMETERY OR CREMATORIUM ASH. NAT'L Park 23d. LOCATION (City, town or county) (State) Bethesda, Md.		
24. FUNERAL DIRECTOR W. Charles C. Jr.			25a. REC'D BY REGISTRAR MAY 11 1967 25b. REGISTRAR'S SIGNATURE Charles Judge		
ADDRESS 517 11th St. Sa			DATE		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96345

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

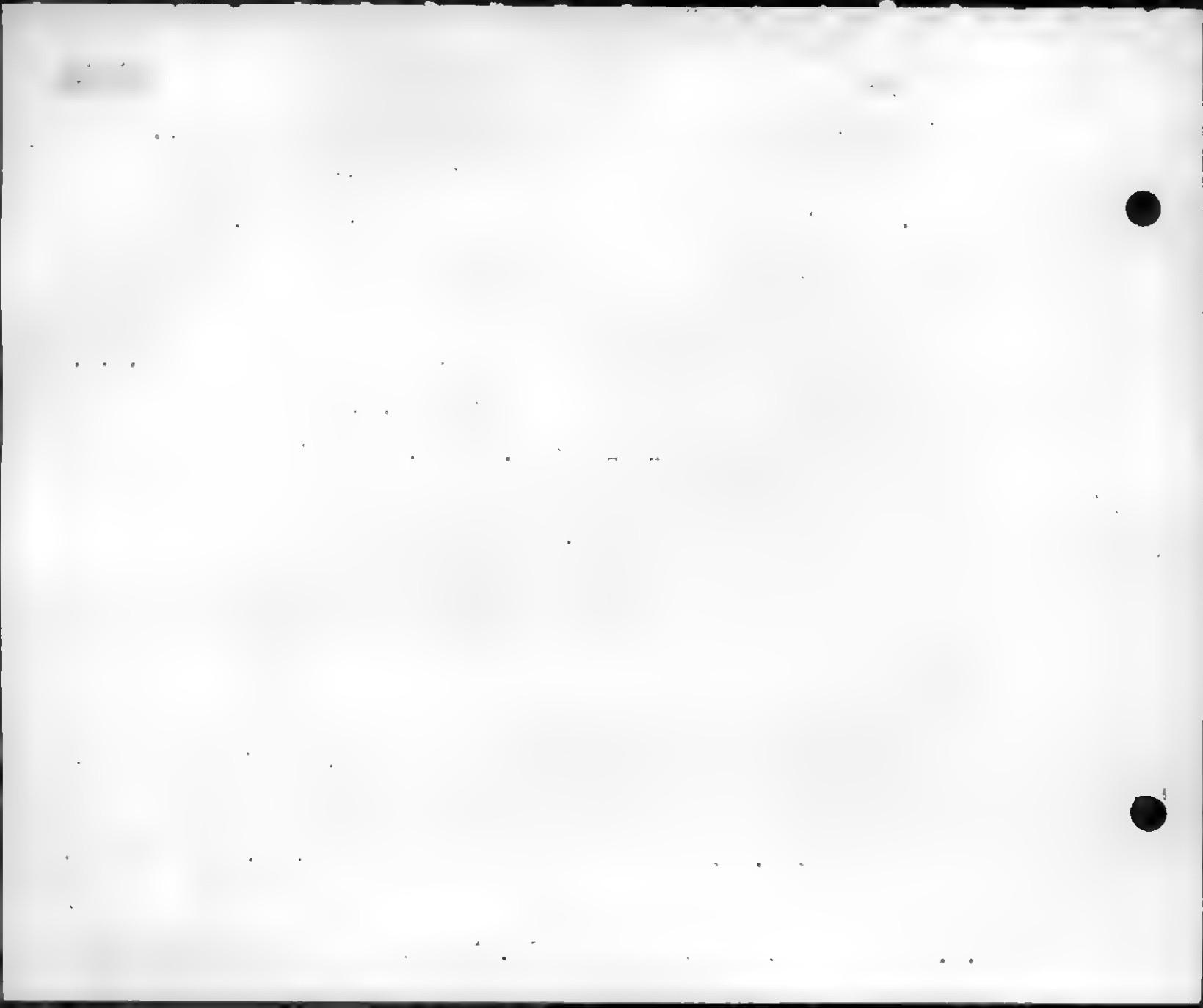
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 7b 16 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		d. STREET ADDRESS 109 Manor Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 109 Manor Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Donald F. Lynch		First	Middle	Last	4. DATE OF DEATH May 17, 1967	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23 1909	9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY Continental Can Co		11. BIRTHPLACE (County & State, or foreign country) Buffalo, N. Y.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Lynch				14. MOTHER'S MAIDEN NAME Grace Curtin		Address Catherine M. Lynch 109 Manor Avenue 21206			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 070-10-4665		17. INFORMANT Catherine M. Lynch		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 4200									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) Congestive heart failure DUE TO				at least			
		(c) Aortic stenosis and mitral insufficiency				3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10 p.m. 10		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> At Work <input checked="" type="checkbox"/> At Work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Death		20f. (City or town) Death		(County) Death	(State) Death
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from 1963 , 19 1967 , to Death , 19 1967 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on May 15 , 19 67 , and that death occurred at 2 PM , from causes and on the date stated above.									
22a. SIGNATURE Crawford N. Kirkpatrick, Jr.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED May 18, 1967	
22c. PHYSICIAN'S NAME (Type) Crawford N. Kirkpatrick M.D.		22d. ADDRESS 6 East Eager St. Balt. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 20, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery		23d. LOCATION (City or Town) Balto. Md.		(County) Balto. (State)	
24. FUNERAL DIRECTOR The Dippel Bro's Inc. 7110 Belair Rd.		ADDRESS		25a. REC'D BY REGISTRAR DAV 10 1967		25b. REGISTRAR'S SIGNATURE Charles J. Dippel			



HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.							
c. LENGTH OF STAY IN 1b 12 months				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Josephs Hospital				d. STREET ADDRESS 9322 Old Harford Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1883	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Pa.			
13. FATHER'S NAME Samuel McClain				14. MOTHER'S MAIDEN NAME Sarah E. Gerber				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address No 220-48-2133 B.Bruce Longbottom Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-vascular renal disease</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c)											
INTERVAL BETWEEN ONSET AND DEATH 20 yrs 20 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 4, 1967</i> to <i>May 4, 1967</i> , that (I) (we) last saw the deceased alive on <i>May 4, 1967</i> , and that death occurred at <i>7:25 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>A. M. Bacon</i>				22b. DATE SIGNED <i>5/5/67</i>							
22c. PHYSICIAN'S NAME (Type) <i>Dr. A. M. Bacon</i>				22d. ADDRESS <i>2810 Taylor Ave., Balto. 34, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>12</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood</i>			
24. FUNERAL DIRECTOR				ADDRESS <i>H.W.Jenkins & Sons Co. 4905 York Rd., Baltw</i>				25a. REC'D BY REGISTRAR <i>5</i>			
								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL _____ **ATTENDING PHYSICIAN** _____ **DEATH**, Page 4
_____ **TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 to be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

36347

J6337

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

606 Highland Ave.

3. NAME OF
DECEASED
(Type or print)

First Middle
Susanne Lyness

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

Md.

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson

d. STREET ADDRESS

606 Highland Ave.

Last

Month

May

Day

23

Year
1967

3. SEX

6. COLOR OR RACE

7 MARRIED NEVER MARRIED

B. DATE OF BIRTH

Oct. 4, 1896

Female

White

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

James Myers

At Home

Baltimore, Md.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE Country or foreign country

12. CITIZEN OF WHAT COUNTRY?

James Myers

14. MOTHER'S MAIDEN NAME

Mary Gertrude McGuigan

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give where or date of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH
5 minutes

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

Arteriosclerotic Heart Disease

(c)

Hypertensive Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (This hospital) attended the deceased from 1956 to 5/23/1967, that (I) (we) last
saw the deceased alive on 5/11/1967, and that death occurred at 3 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Robert T. Parker

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE
SIGNED

May 23, 1967

22c. PHYSICIAN'S
NAME (Type)

ROBERT T. PARKER

22d. ADDRESS

SOUTH BALTO. GENERAL HOSP. BALTO. MD.

(State)

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

23b. DATE THEREOF

5/26/67

23c. NAME OF CEMETERY OR CREMATORIUM

Cathedral Cemetery

23d. LOCATED ON (City, town or county)

Baltimore, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

B. Vernon Lemmon 4611 Park Heights Ave. Balto.

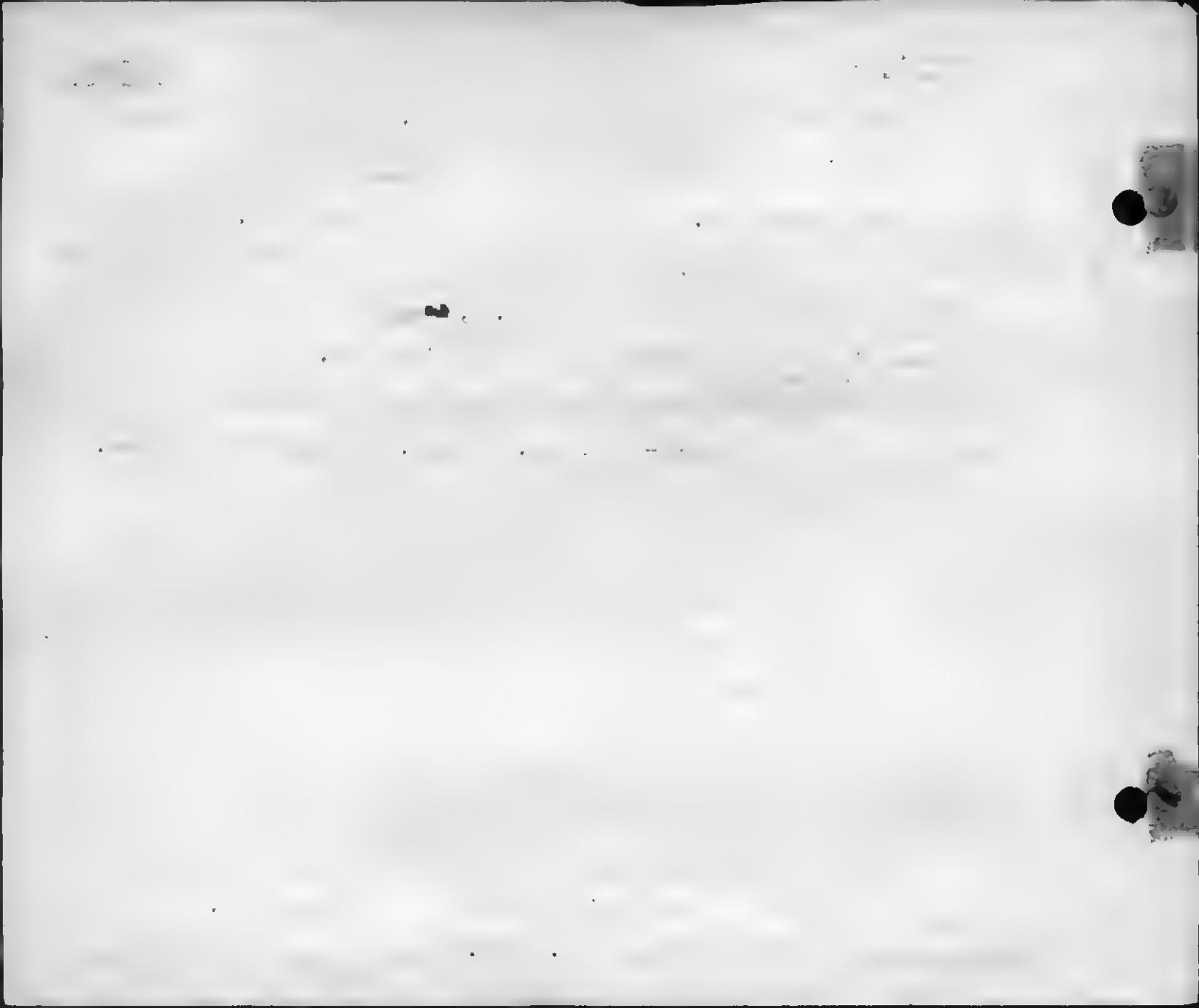
ADDRESS

25a. REC'D BY REGISTRAR

MAY 26 1967

25b. REGISTRAR'S SIGNATURE

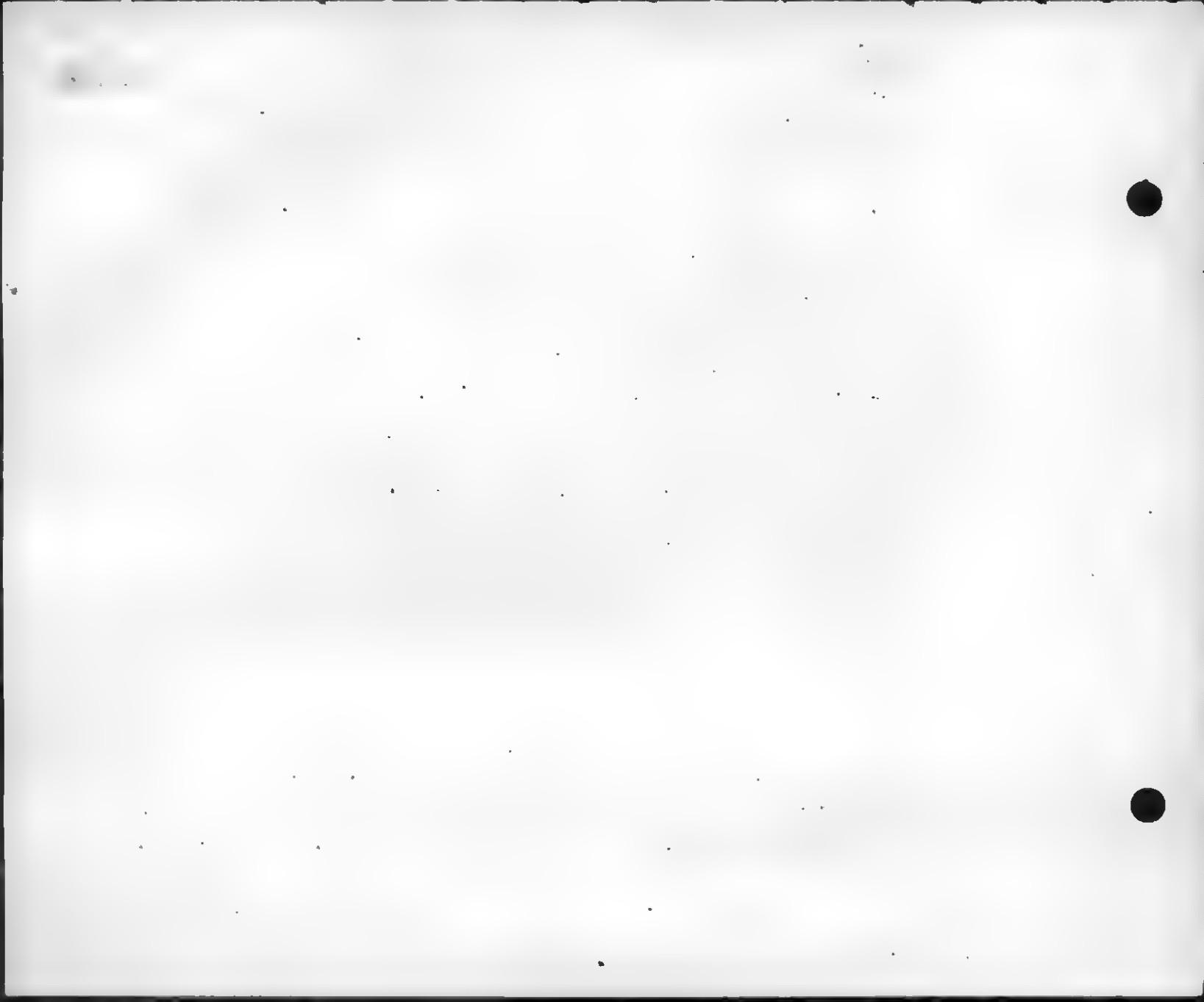
Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				e. STREET ADDRESS 329 Hillen Rd. 21204				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Charles	Middle E.	Last Mack	4. DATE OF DEATH Month May	Month 27	Day 1967						
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-14-22	9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. HOURS 0	13. MIN. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (County & State, or foreign country) Ind.					
13. FATHER'S NAME Edward Mack				14. MOTHER'S MAIDEN NAME Bessie W. Watkins				12. CITIZEN OF WHAT COUNTRY? Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Edward Mack - 325 Limeroy Ave. Tow.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Cirrhosis of the liver 5810 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the cause (a), stating the underlying cause last. (b) Malnutrition DUE TO (c) Cardiac failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH									
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from May 26 , 1967, to May 27 , 1967, that (I) (we) last saw the deceased alive on May 27 , 1967, and that death occurred at 6:45 PM the causes and on the date stated above.													
22a. SIGNATURE B. Del Carmen				22b. DATE SIGNED 5-27-67									
22c. PHYSICIAN'S NAME (Type) Benjamin Del Carmen				22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/31/67				23c. NAME OF CEMETERY OR CREMATORIAL Kensington Mort				23d. LOCATION (City, town or county) Towson Balt Co Md	
24. FUNERAL DIRECTOR B. Del Carmen				ADDRESS 1701 Mc Callum St				25a. REC'D BY REGISTRAR DATE MAY 31 1967				25b. REGISTRAR'S SIGNATURE Chloris J. Indet	



FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

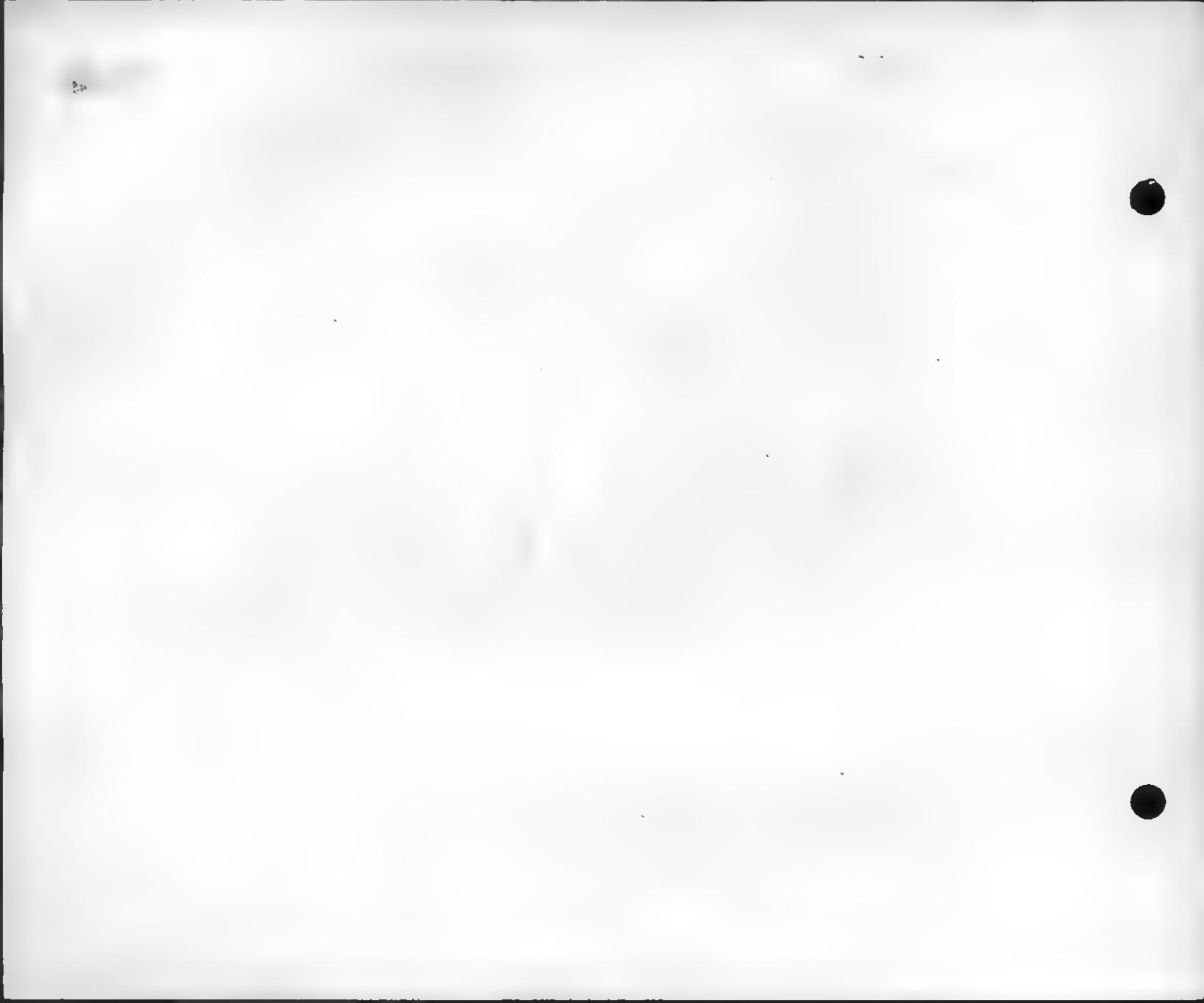
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G-832161 KK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16339

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived before admission) a. STATE Baltimore Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Baltimore	c. LENGTH OF STAY IN b 1b. RURAL AND GIVE NEAREST TOWN Baltimore	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) Saint Joseph Hospital		d. STREET ADDRESS 134 Dartmont Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph	First J	Middle M	Last Mackin
4. DATE OF DEATH May 21 1967	Month May	Day 21	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1907 9. AGE (In years July 31 59 last birthday) 58 yrs
10. US OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired		10b. KIND OF BUSINESS OR INDUSTRY Auto Supply	11. BIRTHPLACE (State or foreign country) BALTIMORE MD
13. FATHER'S NAME James Mackin		14. MOTHER'S MAIDEN NAME MARY Mc Kay	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) Yes		16. SOCIAL SECURITY NO. 210-07-829	17. INFORMANT Fam. L. Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertension		INTERVAL BETWEEN ONSET AND DEATH 5+ yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) Baltimore National
20f. (City or town) BALTIMORE		(County) Md.	
(State) Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		22. DATE SIGNED 5/21/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.			
23a. Cremation REMOVED <input type="checkbox"/>		23b. DATE THEREOF 3-25-67	
23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		23d. LOCATION (City or Town) BALTIMORE	
(County) Md.		(State) Md.	
24. FUNERAL DIRECTOR C. F. Evans & Son 8802 Hartford Rd		ADDRESS 8802 Hartford Rd	
25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15ME (5) 6M 1/67			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06350

CERTIFICATE OF DEATH

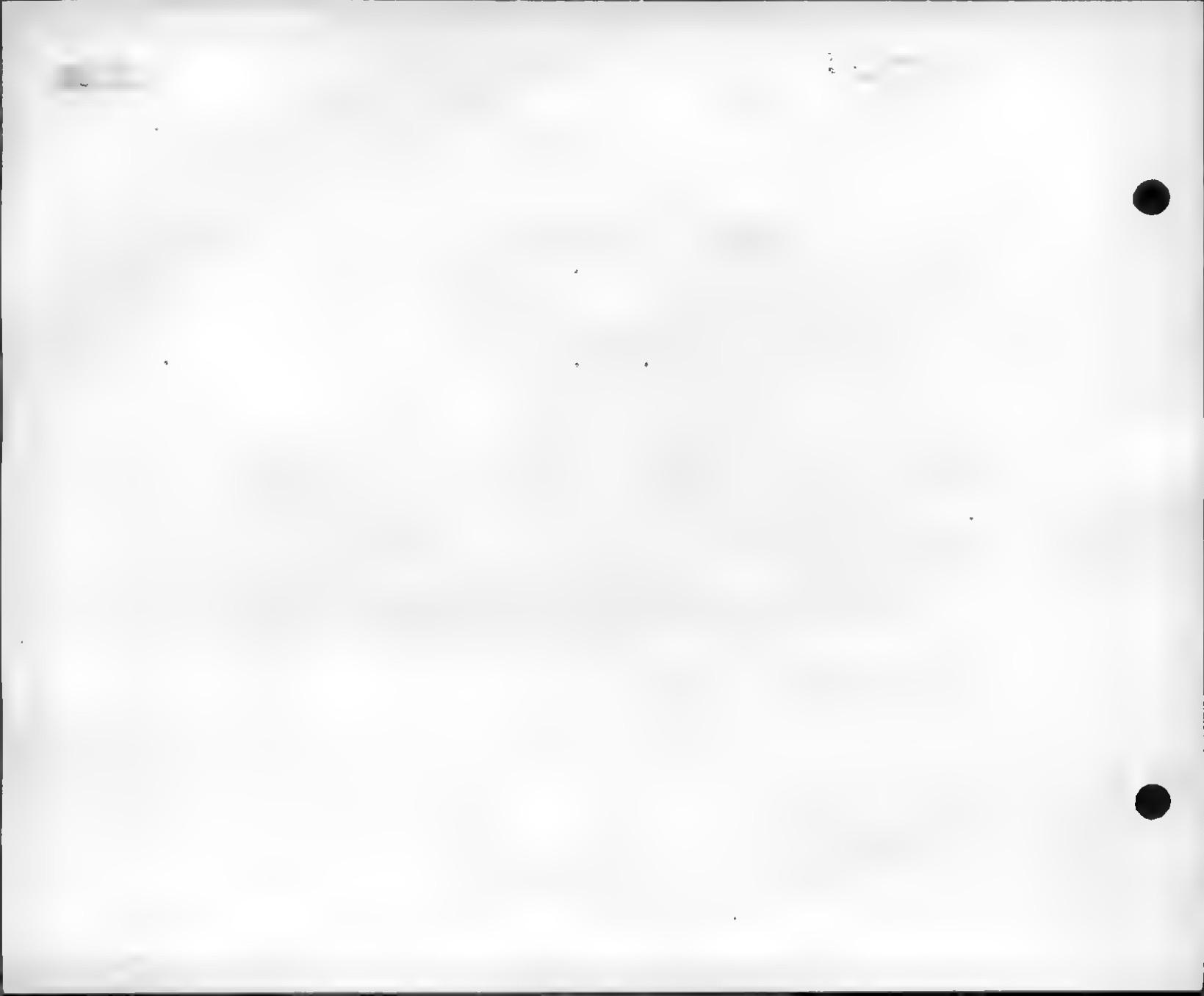
DC210

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 4 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shangri-La Nursing Home		e. STREET ADDRESS 4006 - 38th St.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frank	Middle R.	Last Malzone	4. DATE OF DEATH Month 5 - Day 10 - Year 1967	Month 5 - Day 10 - Year 1967	IF UNDER 1 YEAR Months Days Hours Min	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1896	9. AGE (In years last birthday) 71 yrs	10. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Malzone		14. MOTHER'S MAIDEN NAME Margaret Dalton		15. INFORMANT Mrs. Mary Lila Malzone (above address)		Address	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17. SOCIAL SECURITY NO 386-12-3621		18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intractable Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) <i>Old Myocardial Infarction</i> DUE TO (c) <i>ASCVD</i>		19. INTERVAL BETWEEN ONSET AND DEATH	
20a. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> (CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-10-1967</u> to <u>5-10-1967</u> that (I) (we) last saw the deceased alive on <u>5-10-1967</u> , and that death occurred at <u>9 P.M.</u> from causes and on the date stated above.		22a. SIGNATURE <i>Cesar Valle Caverco</i>		22b. ATTENDING PHYS MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. ADDRESS 7624 Liberty Rd	
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/67		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.		25a. ADDRESS Mt. Rainier, Maryland		25b. REC'D BY REGISTRAR DATE MMI 15 1967	
						25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>	



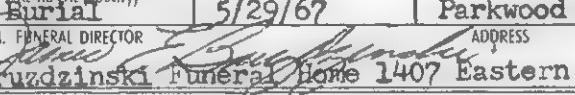
MARYLAND STATE DEPARTMENT OF HEALTH

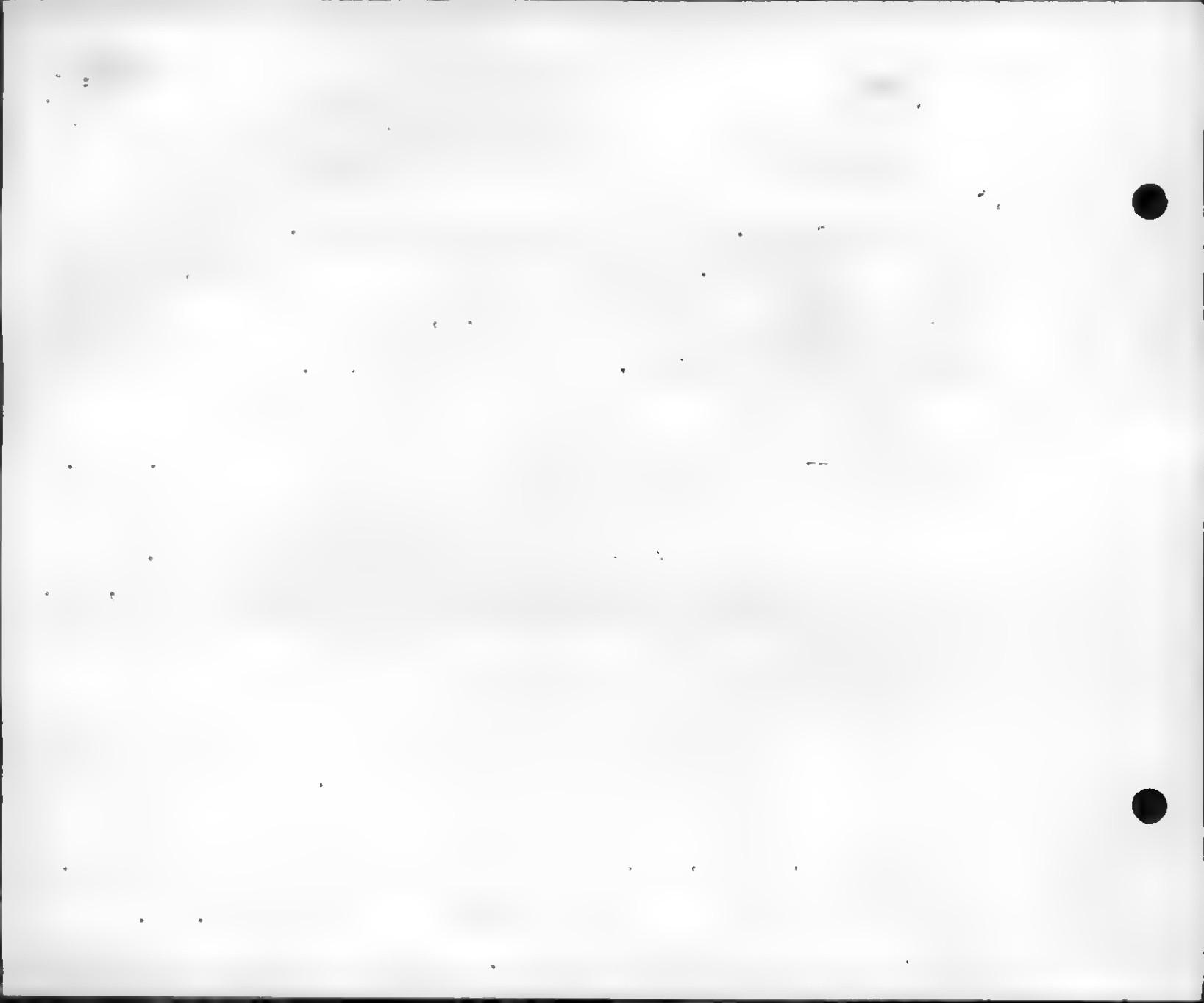
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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06351		16341	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b 	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2262 Monocacy Rd.		e. STREET ADDRESS 2262 Monocacy Rd.	
3. NAME OF DECEASED First GEORGE Middle W. Surname MANNER (Type or print)		4. DATE OF DEATH May 26, Year 1967	
5. SEX Male COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
		8. DATE OF BIRTH Aug. 5, 1901	
		9. AGE (In years last birthday) yrs 65	
10a. LSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Oil Co.	
		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Agusta Manner		14. MOTHER'S MAIDEN NAME Caroline Morecraft	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16. SOCIAL SECURITY NO. 215 03 9093	
		17. INFORMANT Thelma Manner 2262 Monocacy Rd. Balto. 21	
		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction, fatal 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH sudden	
(b) Hypertensive arteriosclerotic C.V.D., dur. 5yr.+ DUE TO (c) Generalized arteriosclerosis, moderate, advanced, 5yrs.+			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) (County) (State)	
21. I certify that (I) (hereinafter attended the deceased from 1/18/63 , 19, to 5/26/67 , 19, that (I) (last saw the deceased alive on 4/24/67 , 19, and that death occurred at 1 a.m. from causes and on the date stated above		22b. DATE SIGNED 5/26/67	
22a. SIGNATURE 		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) R.V. Rangle, M.D.		22d. ADDRESS 2938 St. Paul St., Baltimore, Md. 18	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/29/67	
		23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery	
24. FUNERAL DIRECTOR 		ADDRESS Bruzdzinski Funeral Home 1407 Eastern Ave.	
		25a. REC'D BY REGISTRAR Charles Judge DATE MAY 29 1967	
		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

96352

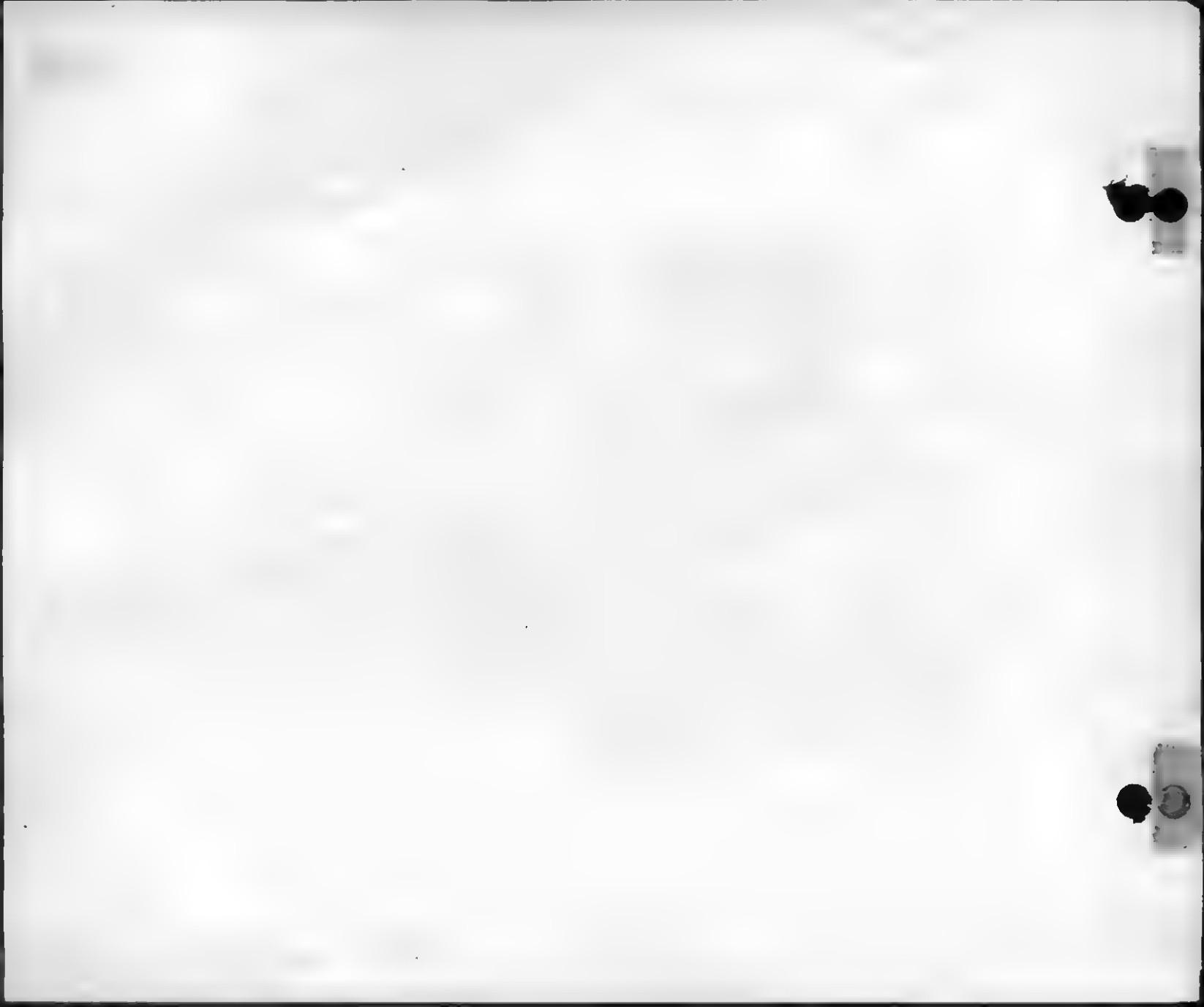
CERTIFICATE OF DEATH

Reg. Dist. No. 36342

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE <i>MD.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>2203 Rockwell Rd.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 28</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>ANNA</i>	Middle <i></i>	Last <i>MARTIN</i>		
4. DATE OF DEATH	Month <i>May</i>	Day <i>2</i>	Year <i>1967</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6- -1889</i>		
9. AGE (In years last birthday) <i>77 yrs.</i>	10. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	11. BIRTHPLACE (State or foreign country) <i>Lith.</i>	12. IF UNDER 1 YEAR Months <i></i>		
13. FATHER'S NAME <i>George Sprainis</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Sereckis</i>	INFORMANT <i>Mr. Andrew Sprainis 2203 Rockwell Rd.</i>	Address <i></i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>	16. SOCIAL SECURITY NO. <i></i>	INTERVAL BETWEEN ONSET AND DEATH <i>None</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) <i>Coronary Thrombosis</i> DUE TO (c) <i>Auto-immune C. O. disease</i>		? ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sensitivity</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>4/26</i> , 19 <i>67</i> , to <i>5/2</i> , 19 <i>67</i> that I last saw the deceased alive on <i>5/1</i> , 19 <i>67</i> , and that death occurred at <i>7:15 A.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>J. C. Mae Langford</i>	ADDRESS (Street, city or town, state) <i>303 N. Rolling Rd. M.D.</i>			DATE SIGNED <i>5/2/67</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-5-67</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood</i>	22d. LOCATION (City, town, or county) <i></i>	(State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thelma L. Hoffmann</i>	ADDRESS <i>3318 Hudson St.</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 8 1967</i>	24b. REGISTRAR'S SIGNATURE <i>Charles J. Hayes</i>		



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5, which may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06353

06343

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 606 Stone Barn Road			d. STREET ADDRESS 606 Stone Barn Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First EDWARD	Middle LAWRENCE	Last MC CLOSKEY	4. DATE OF DEATH May 25 1967	Month Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1929	9. AGE (In years last birthday) 37 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Financial Analyst		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse Elec.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Lawrence McCloskey			14. MOTHER'S MAIDEN NAME Edna Folger		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Anne McCloskey same as 2-d	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO H200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO last _____ (c) _____					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM OR DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles S. Springate</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 25, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)			
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 27, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Woodlawn, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Road Towson, Maryland 21204		ADDRESS		25a. REC'D BY REGISTRAR MAY 29 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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CERTIFICATE OF DEATH							CS344				
1 PLACE OF DEATH 0 COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 0 STATE Md b COUNTY BALTO							
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARMENY		c LENGTH OF STAY IN Tb 23 years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARMENY							
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9210 1/2 Hartford Rd				d STREET ADDRESS 9210 1/2 Hartford Rd			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) CARROLL		First	Middle	Last	4 DATE OF DEATH	Month	Day	Year			
5 SEX	6 COLOR OR RACE	7 MARRIED	NEVER MARRIED	8 DATE OF BIRTH	9 AGE (in years last birthday)	10 IF UNDER 1 YEAR	11 IF UNDER 24 HRS				
M	W	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	Oct 21 - 1903	63 yrs	Months	Days	Hours	Min		
10a USUAL OCCUPATION (Type kind of work done during most of working life even if retired) TRINER				10b KIND OF BUSINESS OR INDUSTRY Letter Press		11 BIRTHPLACE (County & State, or foreign country) BALTO. Md			12 CITIZEN OF WHAT COUNTRY SP 34		
13 FATHER'S NAME Norman McCready				14. MOTHER'S MAIDEN NAME Annie CARROLL							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO 212-09-0463		17 INFORMANT ANNABELLE CALLIS		Address Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY Metastatic carcinoma generalized									INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) 15-50 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to Carcinoma of colon									1 yr		
Due to (c) Due to											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)									19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 710 Charles St		20f (City or town) Baltimore			
								(County) Md			
								(State) Md			
21. I certify that (1) this hospital attended the deceased from 7/10/66 , to 5/9 , 1967, that (1) we last saw the deceased alive on 5/9 , 1967, and that death occurred at 5:45 AM , from causes and on the date stated above.											
22a SIGNATURE Robert E. Martin				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22b DATE SIGNED 5/12/67		
22c PHYSICIAN'S NAME (Type) Robert E. Martin				22d ADDRESS 3201 N. Charles St							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 5-15-67		23c NAME OF CEMETERY OR CREMATORIUM Bethel Memorial Garden			23d LOCATION (City or Town) Bethel				
24 FUNERAL DIRECTOR C. F. Evans & Son		ADDRESS 8807 Hartford Rd		25a REC'D BY REGISTRAR MAY 16 1967			25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06355

CERTIFICATE OF DEATH

J6245

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b STATE MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c LENGTH OF STAY IN b 2 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GBCMC.		e CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) TOWSON	
f STREET ADDRESS 418 DONEGAL DRIVE		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
h PATIENT'S ADDRESS		i DATE OF DEATH 5-2-67	
3 NAME OF DECEASED (Type or print) Edna		j First Middle Last MYRTLE McDONNELL	
k SEX F		l COLOR OR RACE W	
m MARRIED WIDOWED ✓		n NEVER MARRIED DIVORCED □	
o DATE OF BIRTH 9-28-96		p AGE (In years lost birthday) 70 yrs.	
q IF UNDER 1 YEAR Months 0		r IF UNDER 24 HRS Hours 0	
s 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		t 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
u 11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.		v 12 CITIZEN OF WHAT COUNTRY USA	
w 13. FATHER'S NAME CALEB BOND		x 14. MOTHER'S MAIDEN NAME LENA	
y 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		z 16. SOCIAL SECURITY NO 215-48-841	
aa 17. INFORMANT M. RICHARD McDONNELL		bb Address 418 DONEGAL DR.	
cc 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3IX		dd INTERVAL BETWEEN ONSET AND DEATH 5 min.	
ee Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. due to (b)		ff respiratory arrest	
gg due to (c)		hh cerebrovascular accident with probable intracerebral hemorrhage	
ii PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		jj 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
kk 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		ll 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
mm 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		nn 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
oo 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		pp 20f. (City or town) (County) (State)	
qq 21. I certify that (I) (this hospital) attended the deceased from 5-2-67 , to 5-2-67 , that (I) (we) last saw the deceased alive on 5-2-67 , and that death occurred at 3:15 AM , from causes and on the date stated above		rr 22b. DATE SIGNED 5-2-67	
rr 22a. SIGNATURE V.R. Batoyon		ss 22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
tt 22d. ADDRESS 6701 N. Charles ST. BALTIMORE, MD.		uu 23d. LOCATION (City or Town) (County) (State) Parkville Md.	
vv 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		ww 23b. DATE THEREOF 5-2-67	
xx 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parkwood		yy 23d. LOCATION (City or Town) (County) (State) Parkville Md.	
zz 24. FUNERAL DIRECTOR H.W.Jenkins & Sons Co. 4905 York Rd., Baltimore, MD.		aa 25a. REC'D BY REGISTRAR MAY 3 1967	
		bb 25b. REGISTRAR'S SIGNATURE Charles J. Jenkins	



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FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06356

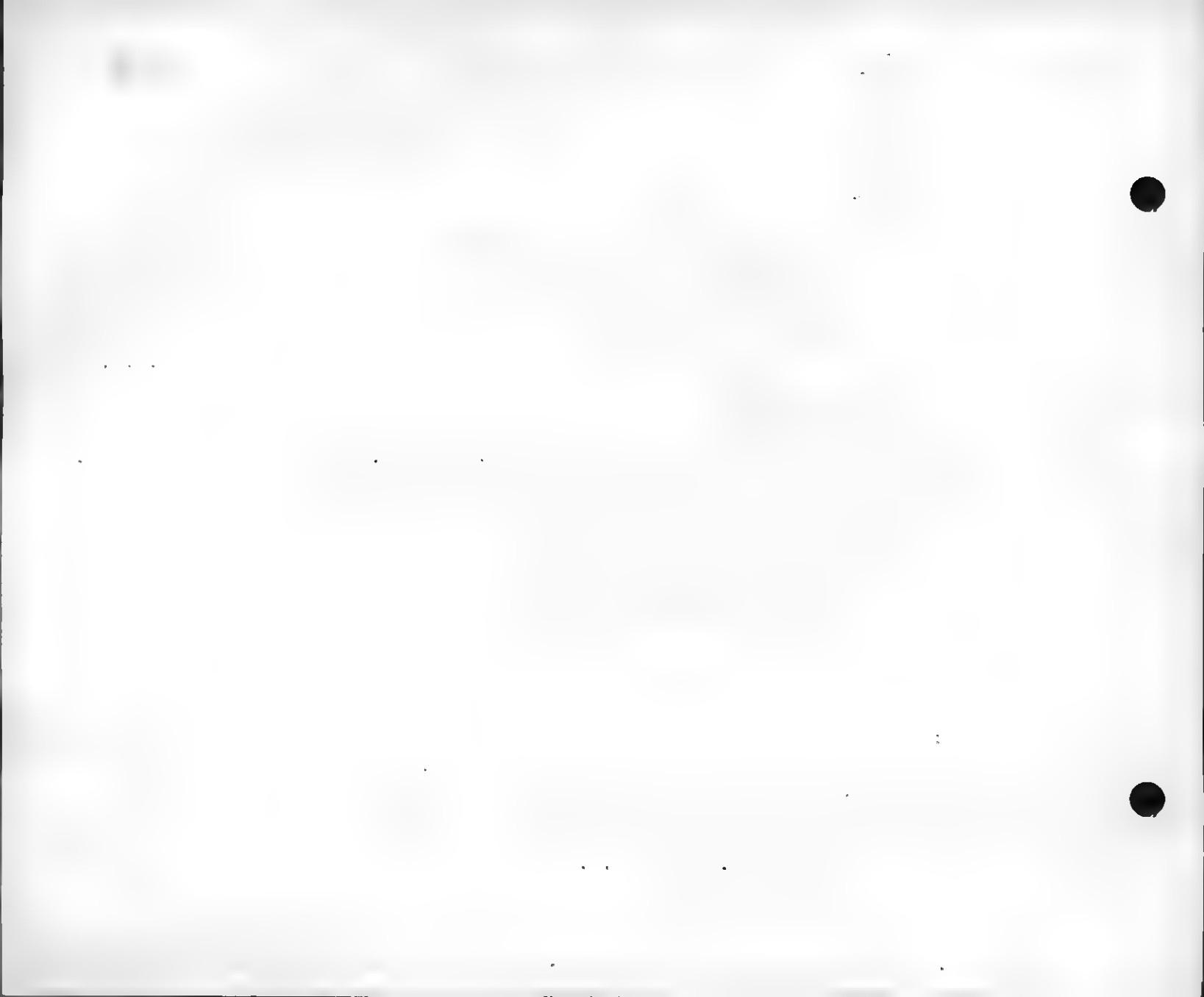
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

J5346

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCH RAVEN RESEVOIR		c. LENGTH OF STAY IN lb Hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 1 New Forrest Court	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) About one-half mile from bridge						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) OLLIE SUE McIllyar		First	Middle	Last	4 DATE OF DEATH Month 5 8 1967	Month	Doy Year 5 8 19 67
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH 9-18-21	9 AGE (in years lost at birthday) 45 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days Hours Min 0 0 0 0
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dallas, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maithias Armstrong				14. MOTHER'S MAIDEN NAME Eula Raines			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 415-26-5743		17. INFORMANT Mr. James D. McIllyar		Address 1 New Forest Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Drowning				INTERVAL BETWEEN ONSET AND DEATH	
118X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Drove car through guard rail and plunged into reservoir		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Reservoir	
20c. TIME OF INJURY Month, Day, Year Hour 20 3:57 pm 5 8 1967						(City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Werner U. Spitz</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-9-67	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/11/67		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Crematory		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		ADDRESS		25a. RECEIVED BY REGISTRAR MAY 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

06357

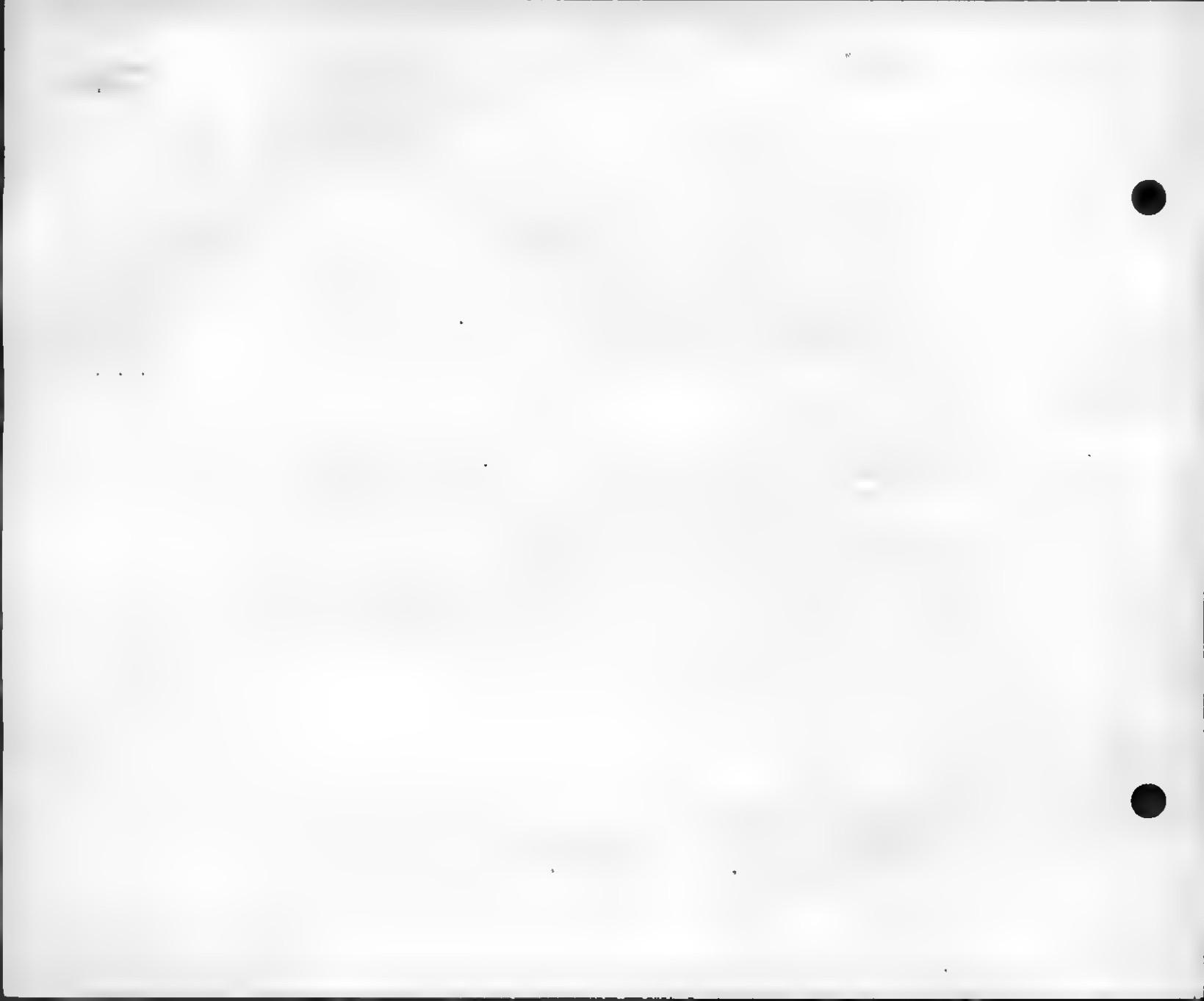
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5247

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas		c. LENGTH OF STAY IN TB Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Church Lane		d. STREET ADDRESS Church Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Roy Dean McMillan		First	Middle	Lost	4 DATE OF DEATH May 7, 1967	Month	Doy	Year
S. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH Feb. 4, 1917	9 AGE (In years last birthday) 50 yrs	B. DATE OF BIRTH Feb. 4, 1917		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Grover McMillan		14. MOTHER'S MAIDEN NAME Cora Moxley		15. ADDRESS Mrs. Mary Edith McMillan Church Lane, Texas				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT		18. INTERVAL BETWEEN ONSET AND DEATH Coronary Occlusion Sudden		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1801 Due To Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due To (c)		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) EXTERNA CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b) INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHARLES F. O'DONNELL, M.D.		
20. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		22. DATE SIGNED 5/7/67		
21. ACTUAL SIGNATURE EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Sparks, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/67		23c. NAME OF CEMETERY OR CREMATORY Jessops Cemetery		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		ADDRESS		25a. REG'D BY REG. STAR DATE MAY 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

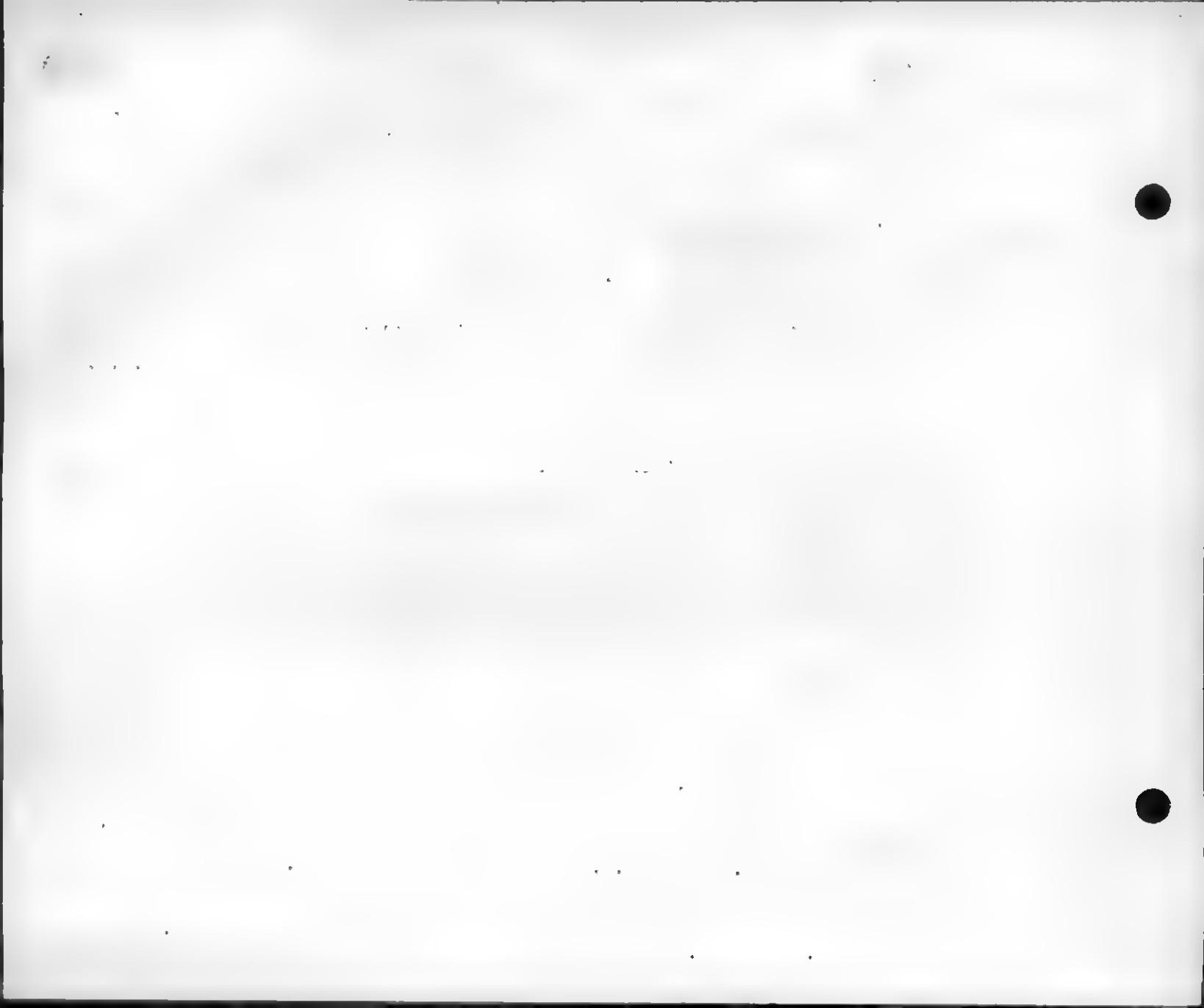
06348

06358

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret		First E.	Middle MEEHAN
4. DATE OF DEATH May 30 1967	Month May	Day 30	Year 1967
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23 1893
9. AGE (In years last birthday) 73 yrs	10. KIND OF BUSINESS OR INDUSTRY Nursing home	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Dieter		14. MOTHER'S MAIDEN NAME Mary Streb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-05-0841-4	
17. INFORMANT Mr. William Meehan		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 45CO DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
General Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1967 , to May 30 , 1967, that (I) (we) last saw the deceased alive on May 30 , 1967, and that death occurred at 1a M, from causes and on the date stated above.			
22a. SIGNATURE <i>Ismael O. Jamora</i>		22b. DATE SIGNED May 30, 1967	
22c. PHYSICIAN'S NAME (Type) Ismael O. Jamora M.D.		22d. ADDRESS 7620 York Rd. Towson 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 2, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Holy Redeemer
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.		25a. REC'D BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE	
		DATE MAY 31 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06359

CERTIFICATE OF DEATH

06349

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH D. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) D. STATE Maryland		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson (Rural)	c LENGTH OF STAY IN 1b	b COUNTY		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore -21236		
d. STREET ADDRESS 2 Henry Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Barbara J. Meise	First Barbara	Middle J.	Last Meise	
4 DATE OF DEATH May 1, 1967	Month May	Day 1	Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-15-01	
9 AGE (In years last birthday) 65 yrs	F UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY Bush Co.		11 BIRTHPLACE (County & State or foreign country) Baltimore, Md.
13. FATHER'S NAME Charles Mohr		14. MOTHER'S MAIDEN NAME Elizabeth Kern		12 CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-32-7314		17. INFORMANT Address Mr. Kenneth Meise 2934 Edgewood Road #34
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular fibrillation		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost. (b) Arteriosclerotic heart disease				
DUE TO (c)				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 2, 1967 , to May 1, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 2:15AM , from causes and on the date stated above.				
22a SIGNATURE <i>M.S. Cockburn</i>		22b DATE SIGNED May 1, 1967		
22c PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d ADDRESS 7620 York Rd., Towson, Md. 21204		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5-4-1967	23c NAME OF CEMETERY OR CREMATORIUM St. Peters Cemetery	23d LOCATION (City or Town) Baltimore, Co. Md.	(County) (State)
24 FUNERAL DIRECTOR <i>Charles M. Funeral Home 7401 Belair Road</i>	ADDRESS 134	25a REC'D BY REGISTRAR MAY 3 1967	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
06360 16350																	
1. PLACE OF DEATH a. COUNTY BALTIMORE			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			c. LENGTH OF STAY IN HB 8-30-62			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOS									b. C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADELPHI								
3. NAME OF DECEASED (Type or print) RUBIN			First	Middle	Last	4. DATE OF DEATH MAY 7 1967	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX M			6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-85	9. AGE (In years last birthday) 8 yrs.	10. IF UNDER 1 YEAR Months	Days	Hours	11. IF UNDER 24 HRS. Minutes							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR			10b. KIND OF BUSINESS OR INDUSTRY CLOTHING			11. BIRTHPLACE (County & State, or foreign country) RUSSIA			12. CITIZEN OF WHAT COUNTRY? RUSSIA								
13. FATHER'S NAME ERIC MENDELSON			14. MOTHER'S MAIDEN NAME HANNAH MENDELSON														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 497-36-8461			17. INFORMANT SPRING GROVE STATE HOS			Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Congestive Heart Failure														
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b)	Pneumonia .													
DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8-30-62 , to 5-7-67 , that (I) (we) last saw the deceased alive on 5-7-67 , and that death occurred at 2pm , from the causes and on the date stated above.															22b. DATE SIGNED 5-7-67		
22a. SIGNATURE Ricardo Ibanez																	
22c. PHYSICIAN'S NAME (Type) RICARDO IBANEZ						22d. ADDRESS Spring Grove Hospital											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 5/9/1967			23c. NAME OF CEMETERY OR CREMATORIUM GEO. WASH. CEM.			23d. LOCATION (City, town or county) HYATTSVILLE, MD								
24a. FUNERAL DIRECTOR Greater Funeral Home 4217 Carroll St. N.W.			ADDRESS						25a. REC'D BY REGISTRAR MAY 9 1967			25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 through 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in case of removal, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 24 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) GEORGE CHARLES MENZEL		f. STREET ADDRESS 3614 LYNDALE AVENUE	
4. SEX MALE	5. COLOR OR RACE WHITE	6. MARRIED X MARRIED WIDOWED DIVORCED	7. NEVER MARRIED □
8. DATE OF BIRTH 4/5/10		9. AGE (In years last birthday) 57 yrs	
10a. U.S. AL OCCUPATION (Give kind of work done during most of work life even if retired) BOOK BINDING		10b. KIND OF BUSINESS OR INDUSTRY BUREAU OF ENGRAVING	
11. BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE A. MENZEL		14. MOTHER'S MAIDEN NAME FLORENCE WENZEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO 214 01 41 57	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)			
BRONCHOCENTRIC CARCINOMA, LEFT SIDE, WITH METASTASES			
INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/26 , 19 67 , to 5/20 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/20/67 19 67 , and that death occurred at 3:45 P.M. from causes and on the date stated above			
22a. SIGNATURE <i>Paulino D. Deocampo</i>		P. ATTENDING PHYS <input type="checkbox"/>	22b. DATE SIGNED 5/21/67
22c. PHYSICIAN'S NAME (Type) PAULINO D. DEOCAMPO, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67	23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery
24. FUNERAL DIRECTOR Schimunek Funeral Home		ADDRESS 3331 Brehms Lane Baltimore, Md.	25a. REC'D BY REGISTRAR MAY 23 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06362

CERTIFICATE OF DEATH

PF352

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard	c. LENGTH OF STAY IN TB 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 900 Cathedral Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MORRIS	First -----	Middle -----	Last MICHAEL
4. DATE OF DEATH May	Month	Day 11	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 9/26/94
9. AGE (In years, at birth) 72 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Clothing Industry	11. BIRTHPLACE (County & State or foreign country) Hudson, New York
13. FATHER'S NAME Jacob Michael		14. MOTHER'S MAIDEN NAME Sarah Litsitz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 215 01 56 30	17. INFORMANT Address Clinical Rcds. VA Hospital, Fort Howard, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Recent	
PULMONARY EDEMA			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost		(b) METASTATIC ADENOCARCINOMA LUNGS, LIVER, ADRENALS AND RIBS (c) ARTERIOSCLEROSIS, GENERALIZED	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
SURGICAL ABSENCE RIGHT COLON (ADENOCARCINOMA)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) VA Hospital, Fort Howard, Md.
20f. (City or town) Fort Howard		(County) Md.	(State) Md.
21. I certify that (1) (this hospital) attended the deceased from May 9, 1967 to May 11, 1967 that (1) (we) last saw the deceased alive on May 11, 1967 and that death occurred at 12:20 PM from causes and on the date stated above.			
22a. SIGNATURE Milton Ginsberg		22b. DATE SIGNED 5/12/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/67	23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National
23d. LOCATION (City or Town) Baltimore, Maryland		(County) Md.	(State) Md.
24. FUNERAL DIRECTOR ZAMINNO FUNERAL HOME		25a. ADDRESS 297 S. Conking St.	25b. REG'D BY REGISTRAR MAY 15 1967
		BALTO. MD.	25c. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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36363

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16253

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
3. NAME OF DECEASED (Type or print) Mattie Blanche		f. STREET ADDRESS None	
4. DATE OF DEATH May 12 1967		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5-28-74	
9. AGE (in years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ret. Own Home	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY Floyd Co. U.S.A.	
13. FATHER'S NAME Marion Summer		14. MOTHER'S MAIDEN NAME Amy Ellan Haley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-18-7751	
17. INFORMANT Records Spring Grove State Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio vascular Disease	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hip fracture (left) and generalized arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-17-67, 19, to May 12, 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 12, 1967, and that death occurred at 4:05 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 5-12-67	
22a. SIGNATURE Anthony J. Young, M.D.		P. M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 5-12-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-15-1967	
23c. NAME OF CEMETERY OR GREMATORIUM Brookview Cem.		23d. LOCATION (City, town or county) Rising Sun, Md.	
24. FUNERAL DIRECTOR Richard L. Goode		ADDRESS Rising Sun, Md.	
25a. REC'D BY REGISTRAR MAY 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

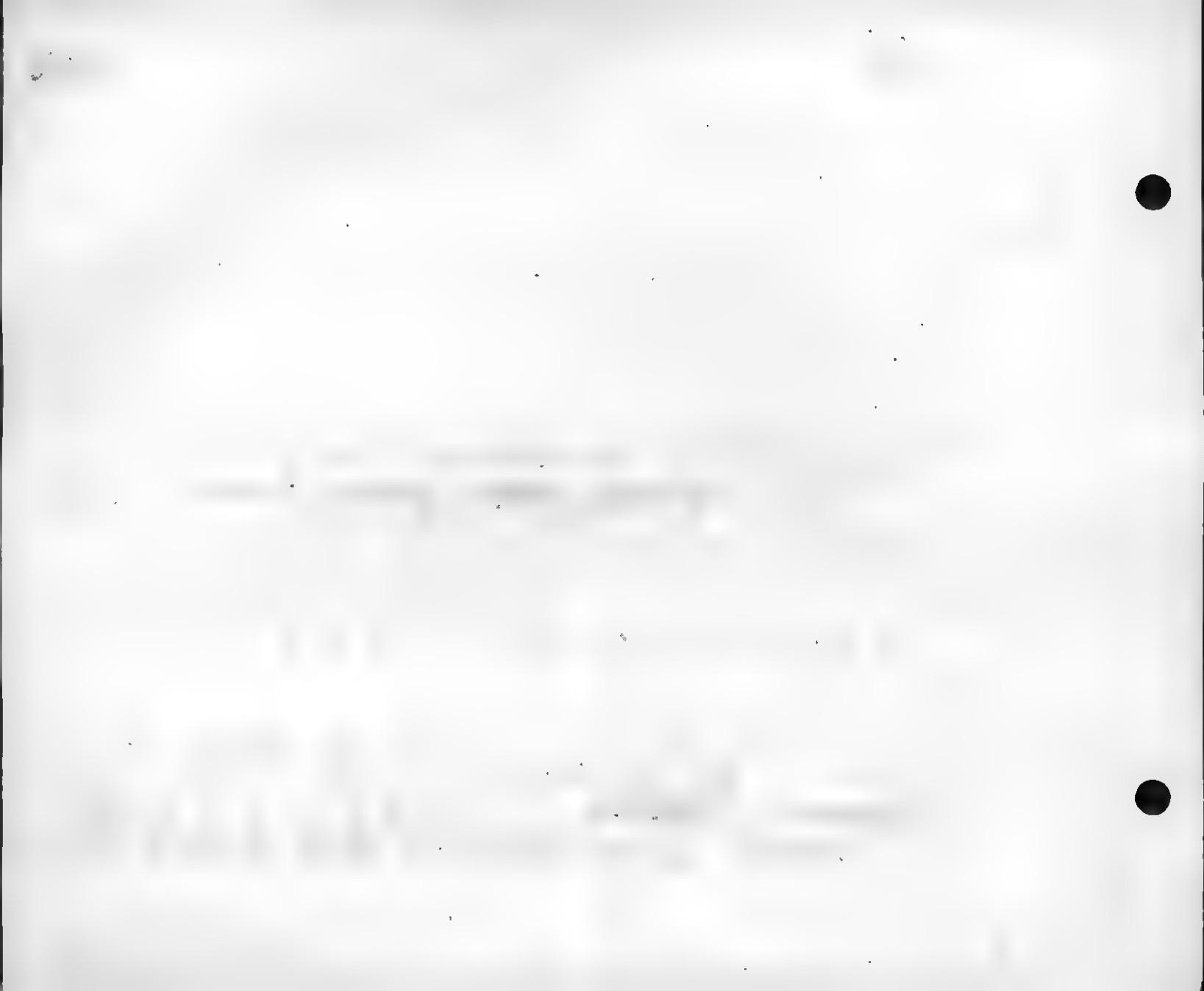
06364

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, until 24 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
a. COUNTY Baltimore MARYLAND		a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3711 Washington Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Randolph Moore		4. DATE OF DEATH Month Day Year MAY 16 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-19-1902		10. AGE (in years from last birthday) 64 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not red) Accountant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? A.S.A.	
13. FATHER'S NAME Charles T. Moore		14. MOTHER'S MAIDEN NAME De Lacy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-6028	
17. INFORMANT Jeanette F. Moore - Same.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 20 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HEMIPLEGIA, RIGHT DUE TO OLD CVA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 14, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from JULY 1957 to MAY 16, 1967 , that (I) (we) last saw the deceased alive on May 14, 1967 , and that death occurred at 10A. M. , from causes and on the date stated above.			
22a. SIGNATURE Marvin Goldstein		22b. DATE SIGNED 5/18/67	
22c. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN		22d. ADDRESS 6001 PARK HEIGHTS AVE. 21215	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-19-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Woodlawn Crem		23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR Ellsworth Armacost		25a. REC'D BY REGISTRAR DATE MAY 22 1967	
		25b. REGISTRAR'S SIGNATURE j Charles Jusges	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16255

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06365					
1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE		b. COUNTY BALTIMORE			
c. LENGTH OF STAY IN 1b MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2430 Smith Ave		d. STREET ADDRESS 2430 Smith Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF First MARY (Type or print)		Middle MORGAN		DATE Last May 14 Month 20 Day 1967	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Not Known		9. AGE (In years last birthday) 95 yrs		10. IF UNDER 1 YEAR Months 95 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Russia	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Not Known		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. EDWARD PERSKIE		INFORMANT EDWARD PERSKIE - SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c)		DUE TO DUE TO DUE TO		Address INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		CONJUGATE HEART FAILURE		7 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) BALTIMORE (State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from 5/12 , 1967, to 5/20 , 1967, that (I) (we) last saw the deceased alive on 5/12 , 1967, and that death occurred at 9A M, from the causes and on the date stated above.				22b. DATE SIGNED 5/20/67	
22a. SIGNATURE J. Zimby		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Sylvan S. Lewis + Son		22d. ADDRESS 4000 W Northern Parkway			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL MAY 20, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Wash. Blvd		23d. LOCATION (City, town or county) BALTO (State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE Sylvan S. Lewis + Son		ADDRESS GARRISON, MD		25a. REC'D BY REGISTRAR MAY 23 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06366

CERTIFICATE OF DEATH

JE356

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before adm.) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 53 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle HENRY	Last MORRIS
4. DATE OF DEATH Month MAY	Month 26	Doy 19	Year 67
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		9. DATE OF BIRTH MAY 21, 1894	
10. KIND OF BUSINESS OR INDUSTRY TAXICAB		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME HARRY MORRIS		14. MOTHER'S MAIDEN NAME BARBARA SACHS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ce) YES WW I		16. SOCIAL SECURITY NO. 217 03 43 39	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COP PULMONALE		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
5020 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) (c)		CHRONIC BRONCHITIS AND PULMONARY EMPHYSEMA	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour: o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH FORT HOWARD, MARYLAND
20f. (City or town) BALTIMORE, MARYLAND		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/3/67 , 19, to 5/26/67 , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/26/67 , 19, and that death occurred at 5:45 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 5/26/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/29/67	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL
23d. LOCATION (City or Town) BALTIMORE, MARYLAND		(County) (State)	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		ADDRESS ZANNINO FUNERAL HOME	25a. REC'D BY REGISTRAR CHARLES JUDGE
		DATE MAY 29, 1967	25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06367

CERTIFICATE OF DEATH

6257

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u>		b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		d. STREET ADDRESS <u>41 BLOOMSBURY AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>41 BLOOMSBURY AVE</u>		d. STREET ADDRESS <u>41 BLOOMSBURY AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRANCES E. MORSBERGER</u>		First	Middle	Last	4. DATE OF DEATH	Month	Year
S. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/1917</u>	9. AGE (in years last birthday) <u>70 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. JS/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Venezuela</u>	
13. FATHER'S NAME <u>Edw. Wm. Morsberger</u>		14. MOTHER'S MAIDEN NAME <u>MARY J. ESPY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> Address <u>EDITH T. MORSBERGER</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO <u>4/21</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO <u>last</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1mo</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>BALTO</u>	(County) <u>Md.</u>	(State) <u>MARYLAND</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1962 to May 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1967</u> , and that death occurred at <u>6:30A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Wilmer K. Gallagher, Jr. M.D.</u>		22b. DATE SIGNED <u>May 29, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, Jr. M.D.</u>		22d. ADDRESS <u>6209 Frederick Ave. Baltimore 28 Md.</u>					
23a. BURIAL/CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/29/67</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>LOUDON PARK</u>		23d. LOCATION (City or Town) <u>BALTO M.D.</u>		
24. FUNERAL DIRECTOR <u>E.S. MACIVARBB</u>		ADDRESS <u>301 FREDERICK RD</u>	25a. REC'D BY REGISTRAR <u>MAI 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1-12

06368

CERTIFICATE OF DEATH

96358

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md. (21093)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Balt. Medical Center		d. STREET ADDRESS 1512 Riderwood Lutherville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Clarence Charles Nash		4 DATE OF DEATH 5 15 67	Month Day Year
S SEX Male	6. COLOR OR RACE Cau.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/20/12
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire chief		10b K ND OF BUSINESS OR INDUSTRY BALTO. COUNTY	9 AGE (In years lost birthday) 54 yrs
13. FATHER'S NAME Charles Leroy Nash		11. BIRTHPLACE (County & State, or foreign country) Balto. Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service Un Known		16. SOCIAL SECURITY NO 218-05-0895	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a) Stens and early peritonitis			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nash
20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nash , 1967, to 5/15 , 1967, that (I) (we) last saw the deceased alive on 5/15 1967, and that death occurred at 6:30 P.M. , from causes and on the date stated above			
22a SIGNATURE Derek A Bruce		22b DATE SIGNED 5/16/67	
22c. PHYSICIAN'S NAME (Type) Derek A Bruce		22d. ADDRESS G. D. N.C.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 5-18-67	23c NAME OF CEMETERY OR CREMATORIAL POPLAR GROVE CEM.
24 FUNERAL DIRECTOR John Burns Son's		ADDRESS Towson, Md.	25a. REC'D BY REGISTRAR MAY 22 1967
			25b. REGISTRAR'S SIGNATURE J. Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PLEASANT STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

J6359

1. PLACE OF DEATH
a. COUNTY

Baltimore

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Towson

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bendix Radio, Joppa Rd.

MARYLAND

c. LENGTH OF STAY IN lb

3. NAME OF
DECEASED
(Type or print)

ROBERT

First

Middle

5. SEX

Male

6. COLOR OR RACE

C

7. MARRIED NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

BRUCE

DIVORCED

NFLFLY

5. PLACE OF DEATH
a. STATE
Md.
b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Baltimore
d. STREET ADDRESS

4591 St. Georges Ave.

Last

4. DATE
OF
DEATH

Month

e. IS RESIDENCE
ON A FARM?
YES NO

Day

Year

May 11 1967

9. AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS.
last birthday Months Days Hours Min.

57 yrs

Months

Days

Hours

Min.

12. CITIZEN OF WHAT COUNTRY?

USA

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Porter

10b. KNOWN BUSINESS OR INDUSTRY

Bendix Communications

11. BIRTHPLACE (State or foreign country)

North Carolina

13. FATHER'S NAME

Weeler Neely

14. MOTHER'S MAIDEN NAME

Millie Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

Yes

WW II

16. SOCIAL SECURITY NO.

110 10 1942

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

(c)

Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH

5 years

Arteriosclerotic Cardiovascular Disease

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. While Not While
p.m. at work at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, 20f. (City or town)
factory, street, office bldg., etc.)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

William A. Pillsbury

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Timonium, Md. (or county)

DATE SIGNED

May 11, 1967

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCAT ON (City, town, or country)

(State)

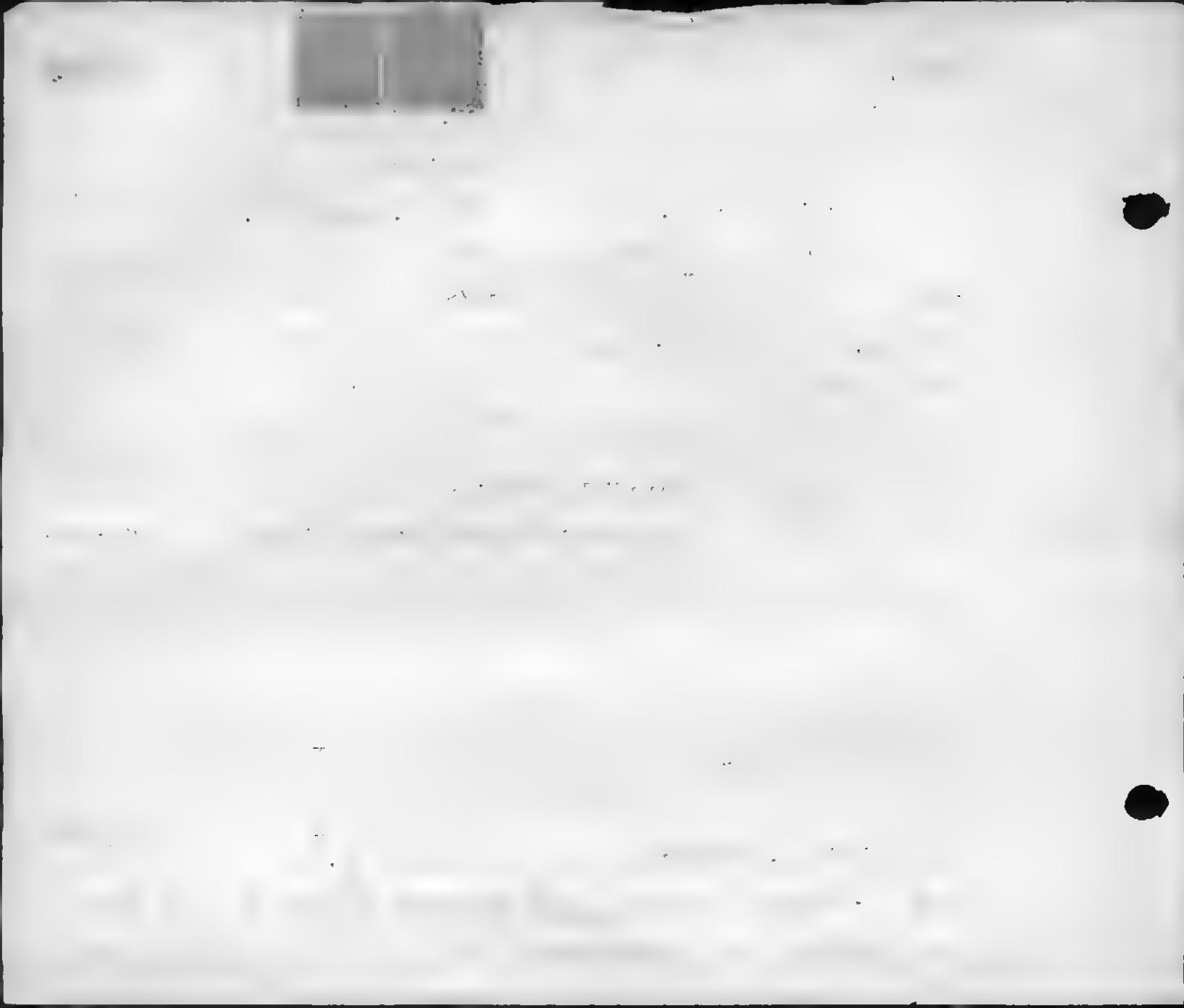
23. FUNERAL DIRECTOR

ADDRESS Church Cem.

24a. REC'D. BY REGISTRAR

24b. REG STRK'S SIGNATURE

5/14/67 Mr. Vernon Presbytarian Power Co. of Baltimore
Glyn St. Johnson 8521 Loch Raven Blvd. DATE MAY 15 1967 Charles Judge



18
FOR STATE
HEALTH DEPT.
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06370

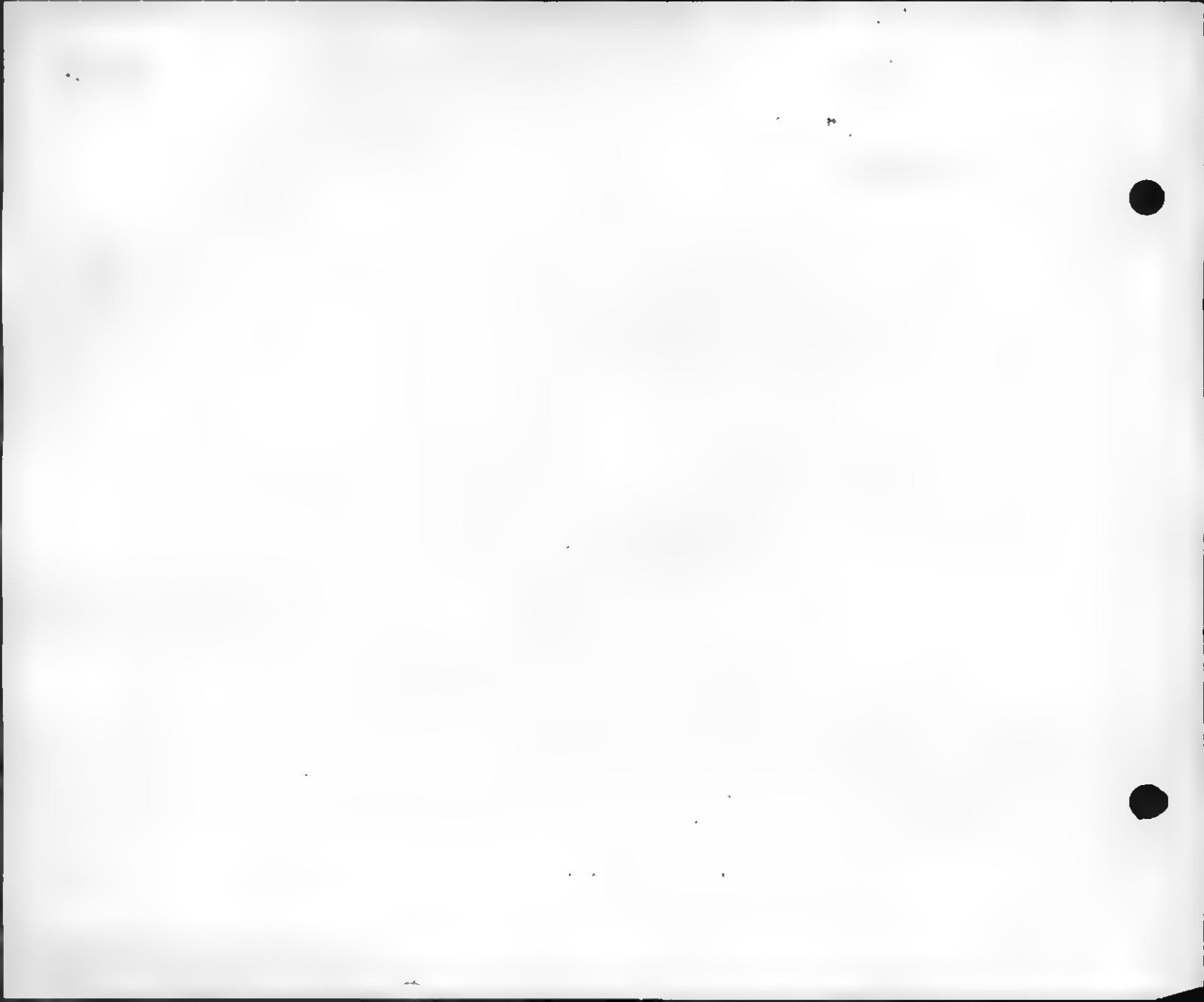
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16360

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland			
c. LENGTH OF STAY IN TB 'Arbutus'				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
d. NAME OF F.I.A.L. OR INSTITUTION (If not in hospital, give street address) 1118 Sulphur Spring Road 21227				e. STREET ADDRESS 1118 Sulphur Spring Road			
3. NAME OF DECEASED (Type or print) ELIZABETH ELLEN NICHOLS				4. DATE OF DEATH Month May 20 1967			
S SEX Female	6 COLOR OR RACE Negro	7 MARRIED WIDOWED X	NEVER MARRIED DIVORCED □	8 DATE OF BIRTH Jan 25, 1912	9 AGE (in years last birthday) 55 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian				11. BIRTHPLACE (State or foreign country) Arbutus, Maryland			
13. FATHER'S NAME Henson Garrett				14. MOTHER'S MAIDEN NAME Margaret Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO 214-18-6456			
17. INFORMANT Mrs. Vivian Schofield				Address 5211 Addison Rd N.E. Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) X				INTERVAL BETWEEN ONSET AND DEATH Arteriosclerotic cardiovascular disease associated			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost X							
(b) DUE TO with diabetes mellitus							
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R. S. Fisher</i>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 5-22-67			
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/25/67		23c. NAME OF CEMETERY OR CREMATORIUM Arbutus Memorial Park	
24. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave		23d. LOCATION (City or Town) Arbutus		(County) (State) Baltimore Co Md	
25a. REC'D BY REG STRR J. Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 23 1967			



12 12 125

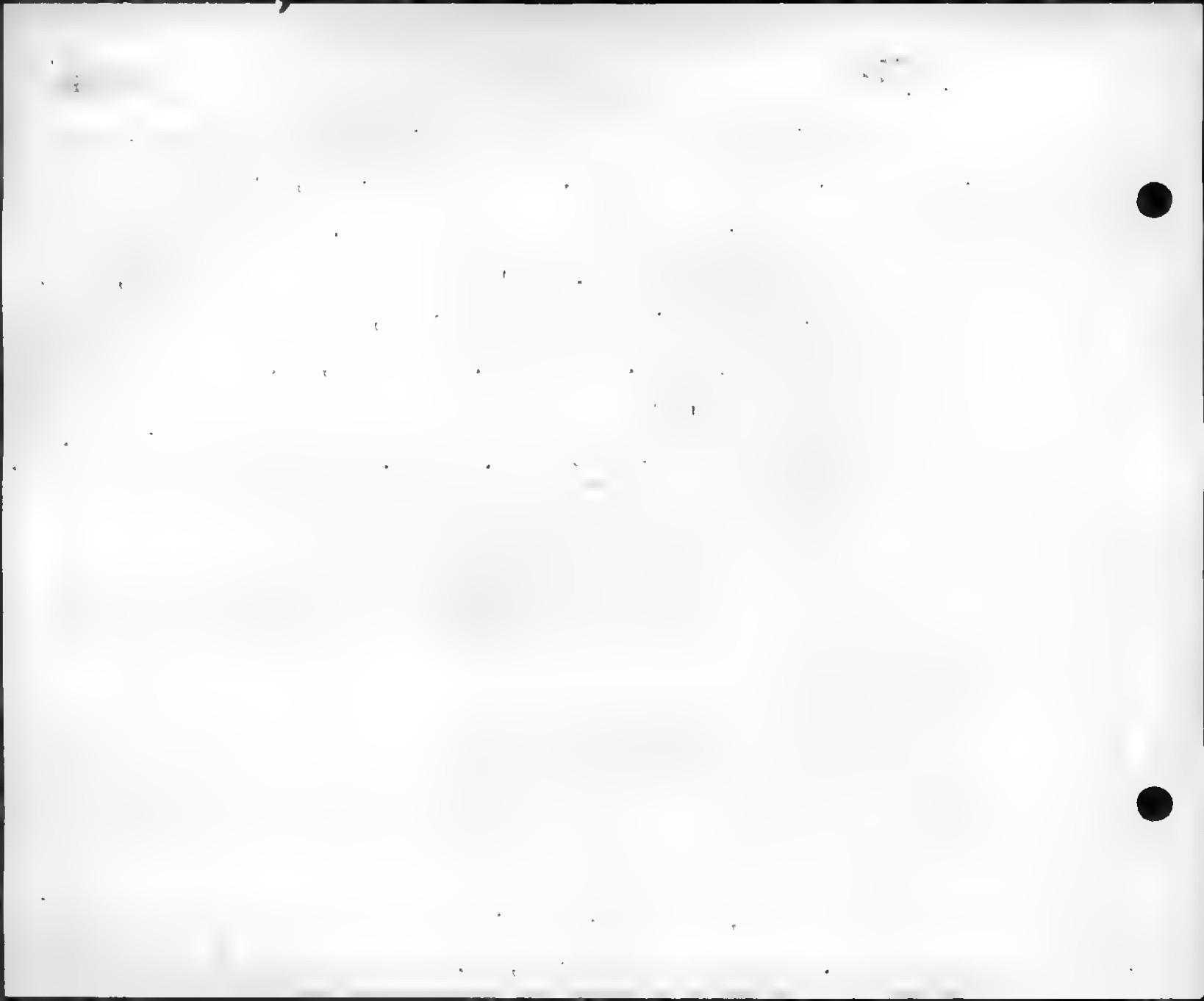
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06372

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Highlands		c. LENGTH OF STAY IN lb 3 Mos.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4048 Mc Dowell Lane		e. STREET ADDRESS 4107 Oak Rd.				
3. NAME OF DECEASED (Type or print) Thomas		First W.	Middle O'Brien			
4. SEX Male	5. COLOR OR RACE White	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	7. NEVER MARRIED DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH August 19, 1897		9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR, Months 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cable Splicer (Ret)		10b. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Elec.	11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.			
13. FATHER'S NAME None		14. MOTHER'S MAIDEN NAME O'Brien				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) No		16. SOCIAL SECURITY NO 212-05-5967	17. INFORMANT Mrs. Jane C. Denney (daughter)			
		Address 307 Penna. Ave Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Gastric Ulcer</i> <i>Pneumonia C. A. of Lung.</i>				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) N.W. 11	20f. (City or town) 64	(County) 3 / 11	(State) 1967
21. I certify that (I) (this hospital) attended the deceased from 1967 , to 1967 , that (I) (we) last saw the deceased alive on 1967 , and that death occurred at 1:45 P.M. , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. SIGNATURE <i>E. M. Ramos M.D.</i>		22b. DATE SIGNED 5/12/67				
22c. PHYSICIAN'S NAME (Type) E. M. RAMOS M.D.		22d. ADDRESS 3927 Annapolis Rd Balt 27				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 13, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	23d. LOCATION (City or Town) Brooklyn	(County) REO	(State) Maryland
24. FUNERAL DIRECTOR Richard V. Singleton		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR Charles Judge	25b. REG STRAR'S SIGNATURE J. Charles Judge	
VR A15 (4) 20 M 1/66		DATE MAY 15 1967				



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

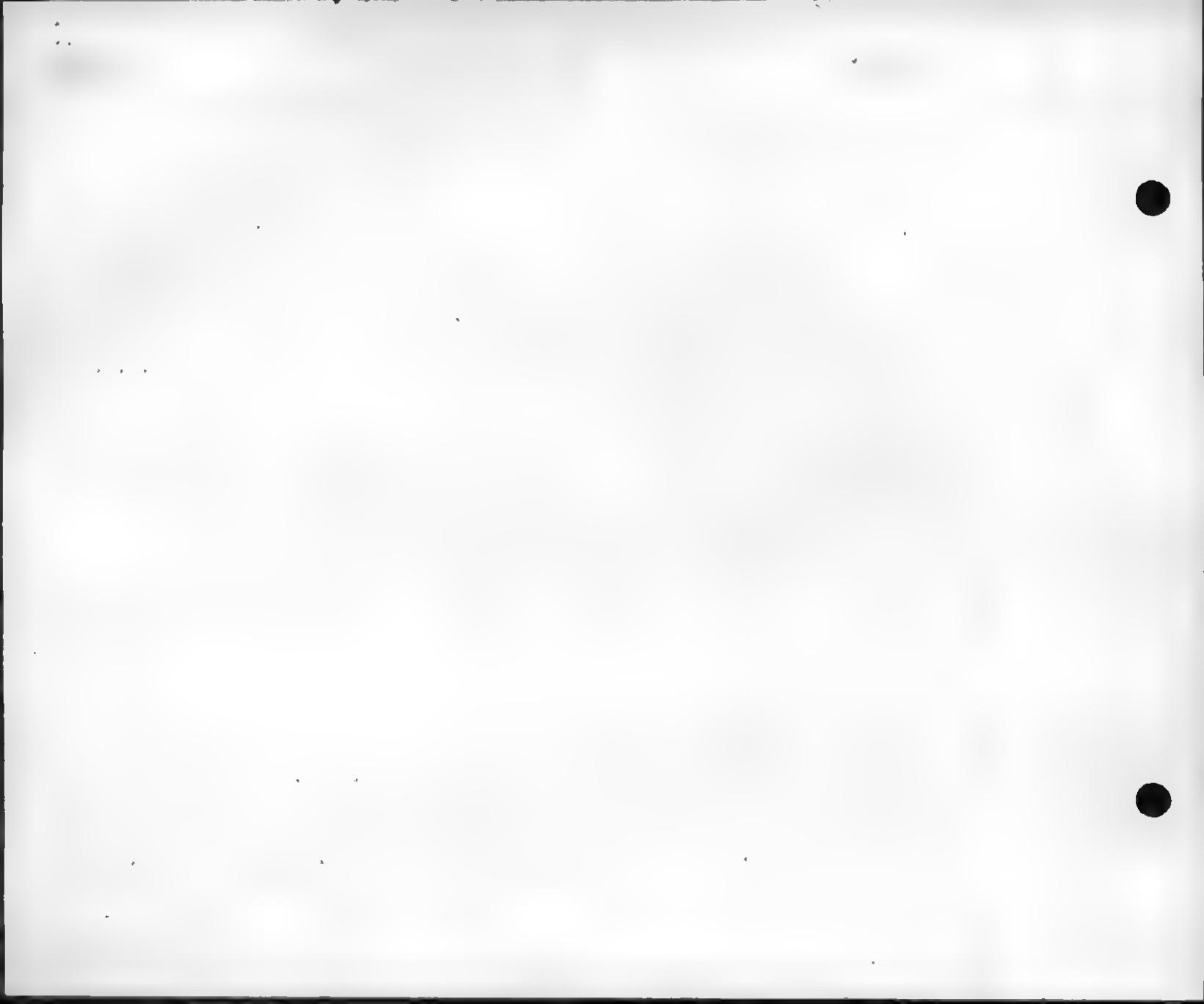
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06373

CERTIFICATE OF DEATH

16783

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 3003 Lavender Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Orrie Wilkens Oldland		First	Middle	1. st	4. DATE OF DEATH Month May
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Aug. 23 1898	9. AGE (In years past birthday) yrs. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (County & State, or foreign country) Penna.	
13. FATHER'S NAME Walter Oldland		14. MOTHER'S MAIDEN NAME Ella ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Rose Oldland 3003 Lavender Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 1801					
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ (c) _____					
DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 30 1967 to May 31 1967 , that (I) (we) last saw the deceased alive on May 31 1967 , and that death occurred at 5.35 AM from causes and on the date stated above					
22a. SIGNATURE Nelson S. de la Paz					
22c. PHYSICIAN'S NAME (Type) Nelson S. de la Paz		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-3-1967		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery	
24. FUNERAL DIRECTOR Lassahn Funeral Home 3401 Belair Rd.		ADDRESS (34)		25a. REC'D BY REGISTRAR DATE JUN 5 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

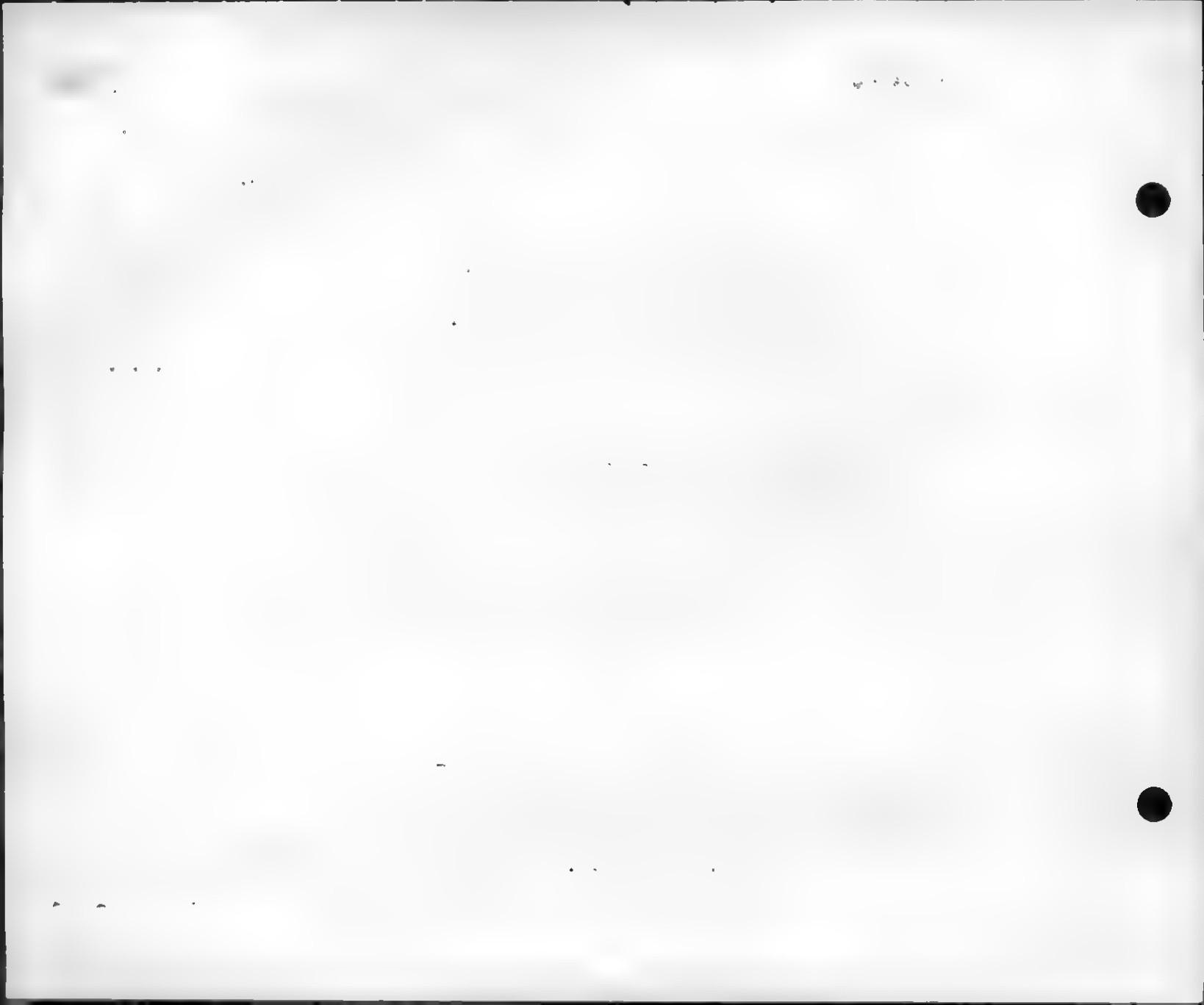
CERTIFICATE OF DEATH

15264

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 through 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 6mth 7dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 Md.	
f. STREET ADDRESS 3023 Second Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
h. NAME OF DECEASED (Type or print) Emma Frances O'Mara		4 DATE OF DEATH Month May 24	Year 1967
5 SEX Female	6 COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		9. AGE (In years last birthday) yrs 78	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Edmund Bryan		14. MOTHER'S MAIDEN NAME Anna Ambrose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-03-0945	17. INFORMANT Address Records: Spring Grove State Hospital
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suppurative bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b). stating the underlying cause (c). DUE TO last. DUE TO (c)			
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Decubitus ulcer	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from 11-17-66 , 19 66 , to May 24 , 19 67 , that (s) (we) last saw the deceased alive on 19 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>		22b. DATE SIGNED 5-24-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 5-27-1967	23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer	23d. LOCATION (City or Town) Baltimore (State) Md.
24. FUNERAL DIRECTOR C.F. Evans & Son	25a. ADDRESS 8802 Harford Rd	25b. REC'D BY REGISTRAR DATE MAY 29 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

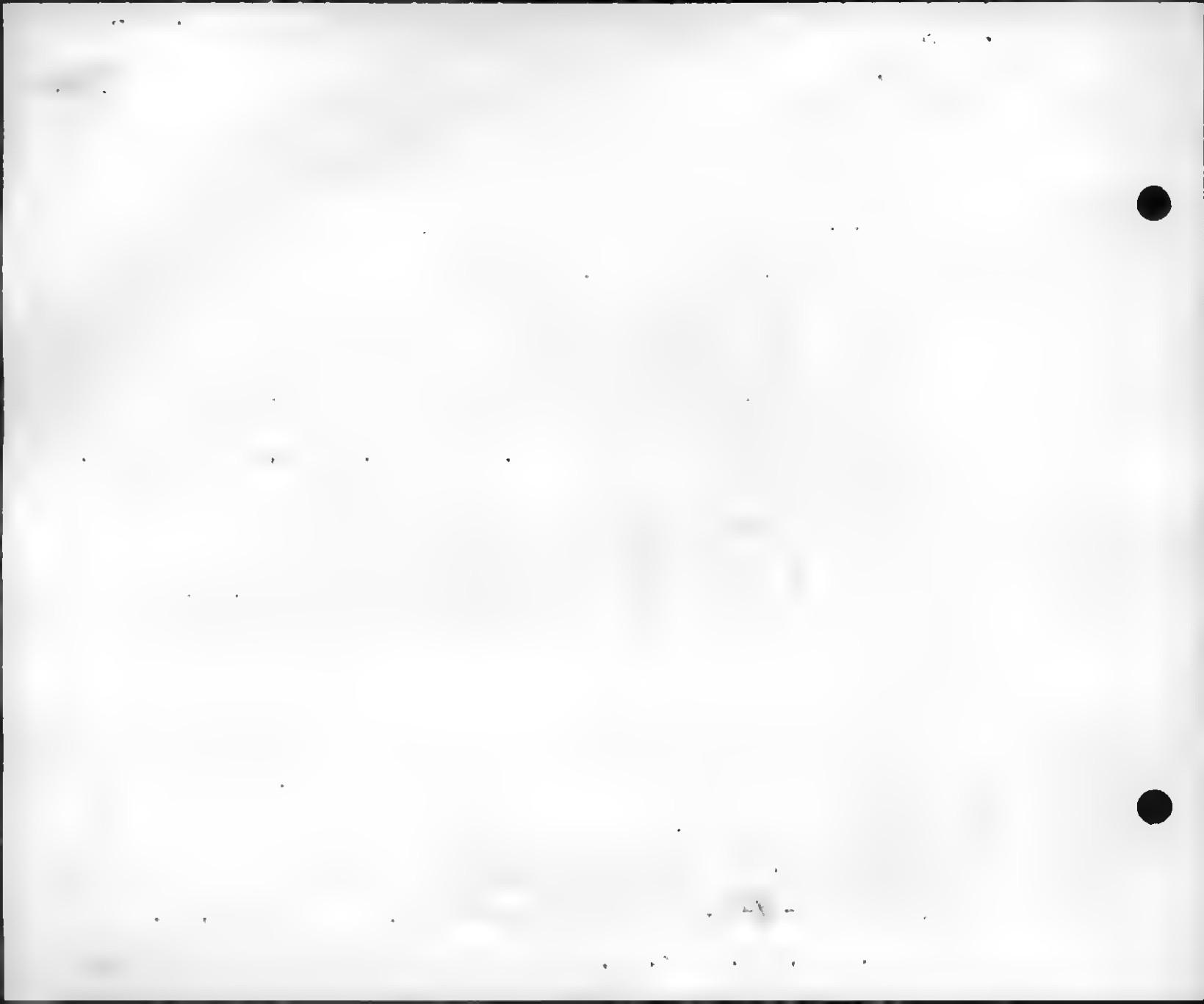
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06375

16265

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN lb	b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. STREET ADDRESS 8415 Hallmark Circle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Teresa	First A.	Middle Panico	4. DATE OF DEATH Month May Doy 14 Year 1967
5. SEX Female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 78 yrs
		11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Guy Gamberdell		14. MOTHER'S MAIDEN NAME Laurina (Mauria) Maurio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220449470	17. INFORMANT Address Mr. Lawrence J. Panico, 1806 Willann Rd. #6
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) Chronic Pulmonary Disease DUE TO (c) Congestive Heart Failure secondary to A.S.C.V.I.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 14, 1967 to May 14, 1967 that (I) (we) last saw the deceased alive on May 14, 1967 , and that death occurred at 6:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Ramon P. Lopez</i>		22b. DATE SIGNED 5-14-67	
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-17-67	23c. NAME OF CEMETERY OR CREMATORIAL CEM. Moreland Memorial Cem.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	
		25a. REC'D BY REGISTRAR MAY 15 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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06376

CERTIFICATE OF DEATH

16766

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please keep two carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle BENJAMIN	Last PARKER
4. DATE OF DEATH MAY 31 1967	Month MAY	Day 31	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/19
9. AGE (In years last birthday) 47 yrs	10. KIND OF BUSINESS OR INDUSTRY Fisher Auto Parts	11. BIRTHPLACE (County & State or foreign country) Benson, North Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lester Parker	14. MOTHER'S MAIDEN NAME Eleanora Beasley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II	16. SOCIAL SECURITY NO 217-03-85-37	17. INFORMANT Clinical Records, VAH, Fort Howard, Maryland	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)			
INTERVAL BETWEEN DEATH AND DEATH MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from May 29, 1967 , to May 31, 1967 , that (we) last saw the deceased alive on May 31, 1967 , and that death occurred at 4:00AM from causes and on the date stated above			
22a. SIGNATURE <i>George C. McElfrick, M.D.</i>	22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	DATE SIGNED 5/31/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELFRICK, M. D.	22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/3/1967	23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR H. J. Tickner & Sons	ADDRESS North & Pennsylvania Baltimore, Maryland	25a. REC'D BY REGISTRAR JUN 1 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

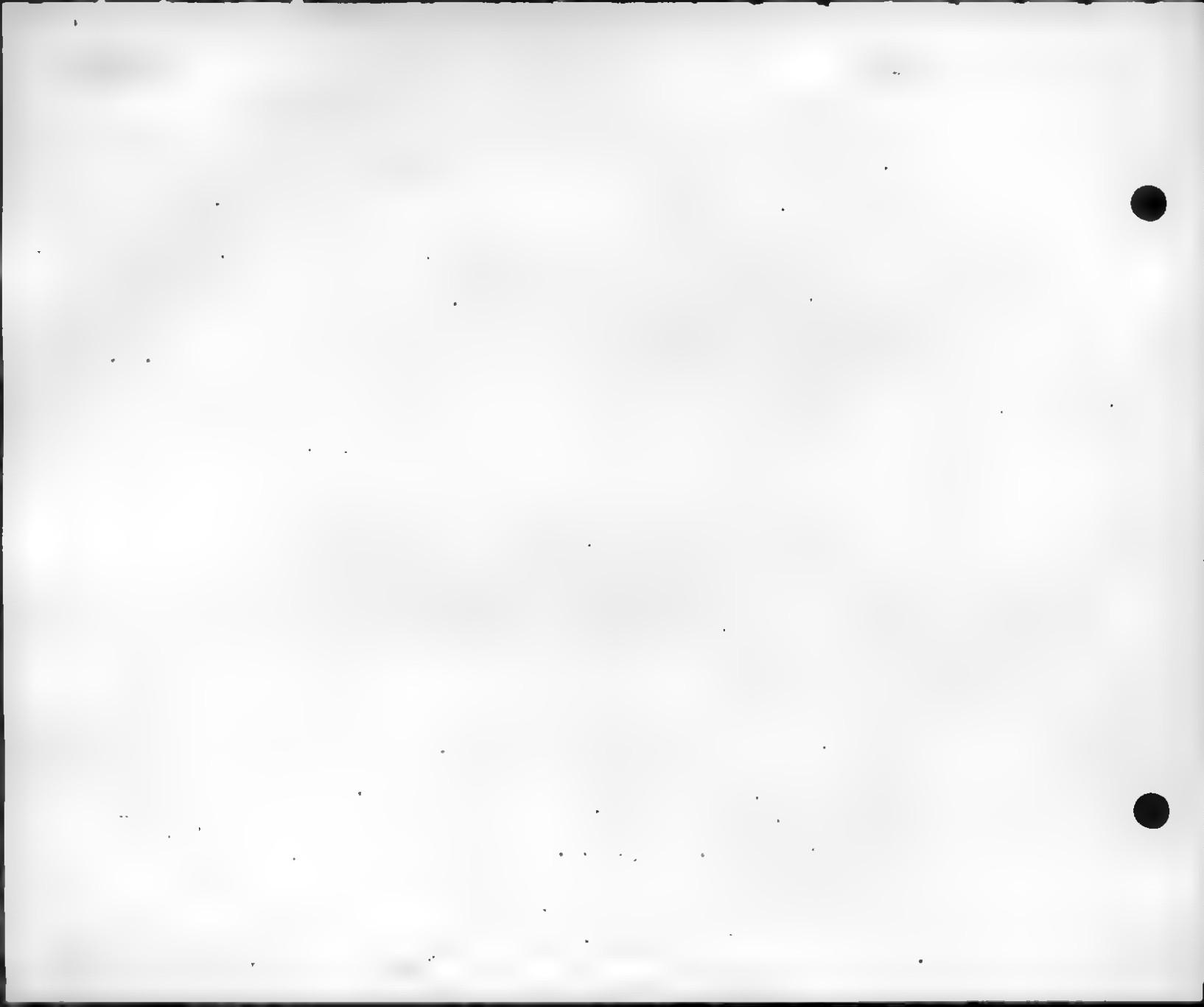
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										15367	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY										2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Baltimore MARYLAND					a. STATE Maryland	b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. LENGTH OF STAY IN 1b	lyr 5 mth 18 d	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS	419 North Pulaski Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First Mary	Middle Bessie	Last Pearce	4. DATE OF DEATH	Month May	Day 2	Year 1967		
5. SEX female			6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1891	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Domestic			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Samuel Pearce			14. MOTHER'S MAIDEN NAME Phoebe Christina Boyd			Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 9			17. INFORMANT					
Records: SPRING GROVE STATE HOSPITAL										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 411A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia (c) DUE TO DUE TO DUE TO	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Nov. 14, 1962, to May 2, 1967, that (I/we) last saw the deceased alive on May 2, 1967, and that death occurred at 8:30 A.M. from the causes and on the date stated above.									a.	22b. DATE SIGNED 5-2-67	
22a. SIGNATURE Anthony J. Young, M.D.						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - 5-5-67			23b. DATE THEREOF Packwood			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City, town or county) (State) Balt. County Md.		
24. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			Francis St. Miller 2101 Frederick Ave. DATE MAY 4, 1967		
									Anthony Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

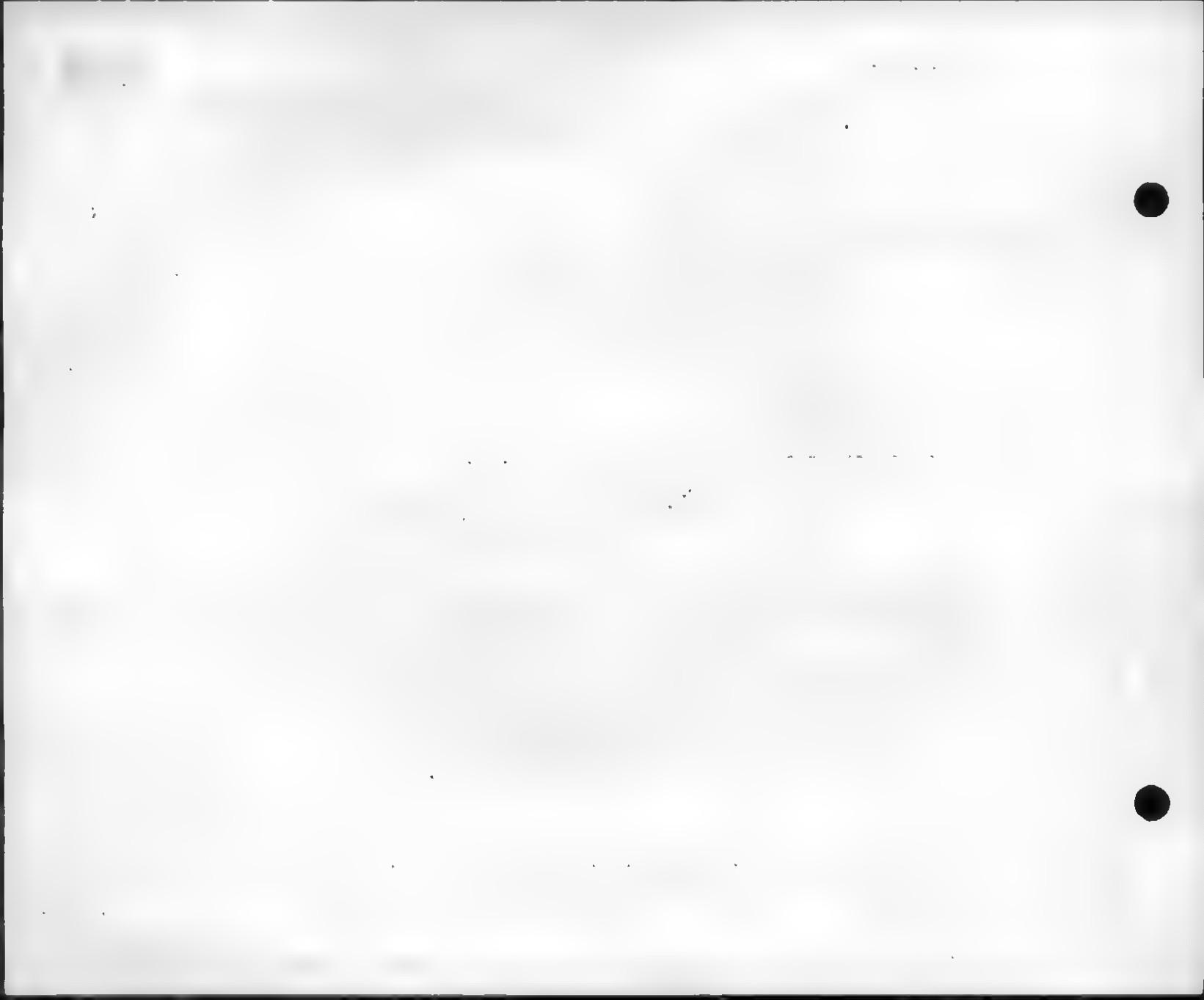
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06378

CERTIFICATE OF DEATH

15268

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas		c. LENGTH OF STAY IN b. years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 138 Church Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DORA ELIZABETH PERRY		4. DATE OF DEATH May 2, 1967	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 21, 1880		9. AGE (In years last birthday) 86 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Green		14. MOTHER'S MAIDEN NAME Mary Elizabeth Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-54-2912J1	
		17. INFORMANT Mr. C. Lester Perry, Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thromboses multiple		INTERVAL BETWEEN ONSET AND DEATH 332X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Cerebral Arteriosclerosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4127/19
20f. (City or town) 4127/19		(County) (State) 4127/19	
21. I certify that (I) (this hospital) attended the deceased from May 24, 1967 to May 27, 1967 , that (I) (we) last saw the deceased alive on 4/29/67 , and that death occurred at 4127/19 from causes and on the date stated above.			
22a. SIGNATURE Donald O. Wood, M.D.		ATTENDING PHYS. M.D.	22b. DATE SIGNED 5/3/67
22c. PHYSICIAN'S NAME (Type) Donald O. Wood, M.D.		22d. ADDRESS York Rd. and Greenmeadow, Timonium, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 5, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Jessop Cemetery
23d. LOCATION (City or town) Sparks, Baltimore Co., Md.		(County) (State)	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204	25a. REC'D BY REGISTRAR MAY 5 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

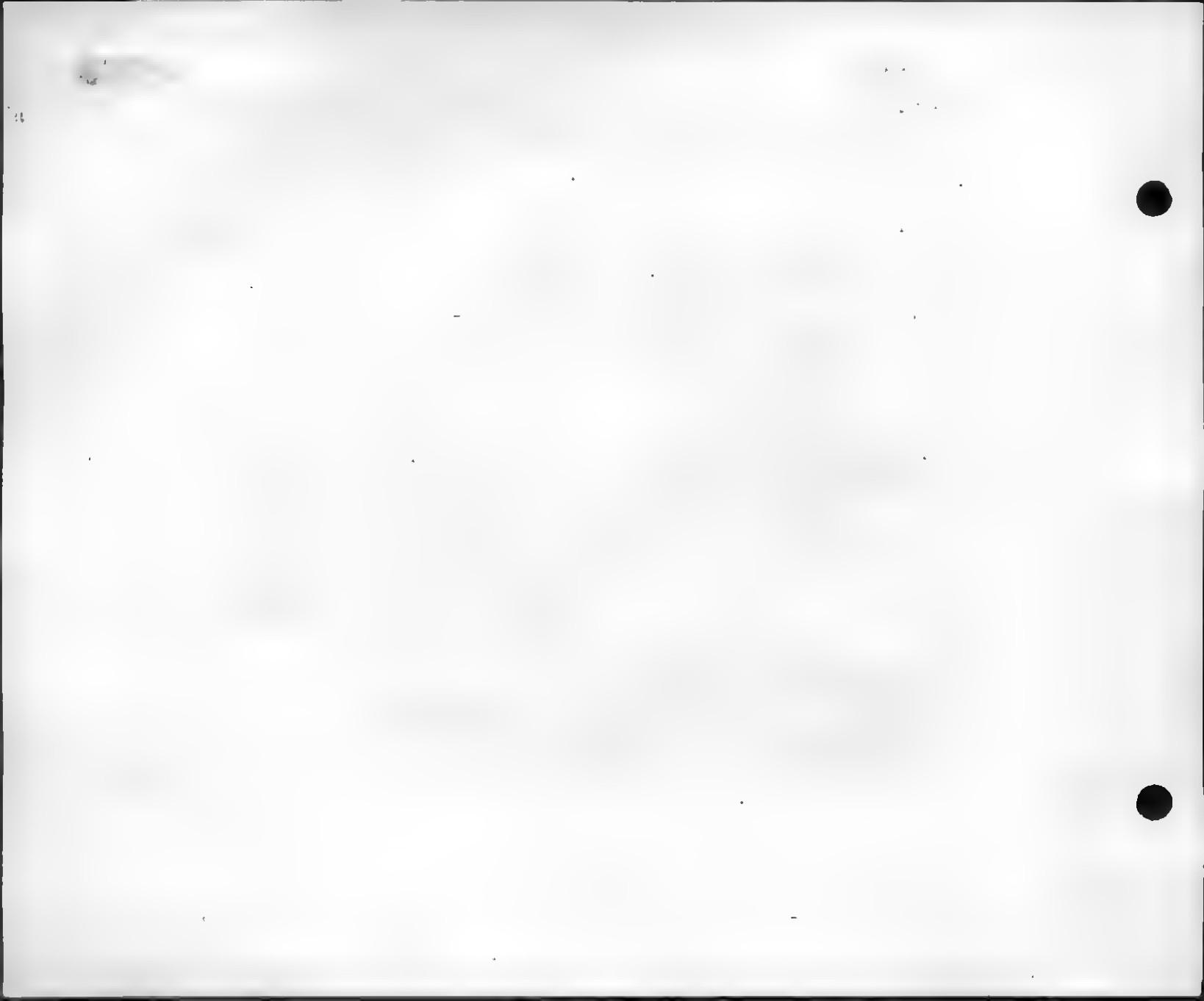
06379

CERTIFICATE OF DEATH

06369

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb 7 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3604 Tulsa Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3 NAME OF DECEASED (Type or print) Margaret A. Pfeiffer		4 DATE OF DEATH Month May 29 1967	
S SEX Female	6. COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. US-AL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		8. DATE OF BIRTH 1-27-1875	
10b. KIND OF BUSINESS OR INDUSTRY		9 AGE (in years last birthday) 92 yrs	
10c. FATHER'S NAME John Murk		11. BIRTHPLACE (County & State, or foreign country) Baltimore County	
13. MOTHER'S MAIDEN NAME Mary Blum		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO None	
17. INFORMANT Carroll L. Pfeiffer - 645 Coventry Rd. #4		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost		DUE TO (b) Cerebral Thrombosis DUE TO (c) Diverteritis of Sigmoid Colon	
		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
4 days		2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Generalized arterial sclerosis	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 2 - 1960 , to May 29, 1967 , that (I) (we) last saw the deceased alive on May 27 1967 , and that death occurred at 1154 M , from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Earl L. Chambers		22b. DATE SIGNED 5/31/67	
22c. PHYSICIAN'S NAME (Type) Earl L. Chambers -		22d. ADDRESS 4108 Liberty Pls Balt. Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-1-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Ellsworth Armacost - 4600 Liberty Hghts.		25a. REC'D BY REGISTRAR JUN 1 1967	
		25b. REGISTRAR'S SIGNATURE <i>R. Ellsworth</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician.
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. pages 1 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i>				2. USUAL RESIDENCE (Where deceased lived, if institution Residenc before admission) a. STATE <i>Md.</i>				3. PLACE OF DEATH b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>					
c. LENGTH OF STAY IN 1b <i>4 yrs</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>				d. STREET ADDRESS <i>Aged Woman 34 ages Mens Home 564 Delaware Ave.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>AnneTTA</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>F. W.</i>		First	Middle	Lost	4. DATE OF DEATH <i>Phipps</i>	Month	Day	Year	May 28 1967				
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH <i>July 18-1876</i>	9. AGE (in years last birthday) <i>90 yrs</i>	F. UNDER 1 YEAR Months	DAYS	IF UNDER 24 HRS Hours	Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>				10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Phipps, James</i>				14. MOTHER'S MAIDEN NAME <i>Higle, Josephine</i>				Address <i>M. Elta McElfresh 615 Chestnut Ave</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>215 48 7946</i>		17. INFORMANT <i>M. Elta McElfresh</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4200</i>				Gardiac insufficiency									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i></i>				DUE TO (b) Arteriosclerotic heart disease				years					
				DUE TO (c) Generalized chronic arteriosclerosis, systemic."									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <i></i>		(County) <i></i>		(State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>March 3, 1960</i> , to <i>May 28, 1967</i> , that (II) (we) last saw the deceased alive on <i>May 28, 1967</i> , and that death occurred at <i>2 A.M.</i> , from causes and on the date stated above.													
22a. SIGNATURE <i>Edwin B. Jarrett</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED <i>5/28/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Edwin B. Jarrett, M.D.</i>				22d. ADDRESS <i>11 East Chase St., City-2.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 31, 67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Govans Presbyterian</i>		23d. LOCATION (City or Town) <i>Towson, Md.</i>		(County) <i>Balto.</i>		(State)			
24. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson, Md.</i>				ADDRESS				25a. RECD BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
								DATE MAY 31 1967					



da 9526

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06381

CERTIFICATE OF DEATH

07844

1 PLACE OF DEATH Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Hanover	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN TB 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First HARRY	Middle CORNELIUS	Last PIERCE
4. DATE OF DEATH MAY 18 1967	Month MAY	Day 18	Year 1967
5 SEX M.	6 COLOR OR RACE N.	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-06
9. AGE (In years lost birthday) 61 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) N.J.
12 CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME JOHN PIERCE		
14. MOTHER'S MAIDEN NAME ANNIE BUTLER	15. SOCIAL SECURITY NO 231-18-5326		
16. INFORMANT Records, Mount Wilson State Hospital	17. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore (County) Maryland (State) M.D.		21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above	
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D.		22d. ADDRESS Superintendent Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 22, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Anthony's Lane Baltimore Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Frank D. Newell		25a. RECED BY REGISTRAR ADDRESS Marionville, Md. DATE JUN 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles Jno.	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06382

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD.		b. COUNTY BALTO.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS					
CATONSVILLE				CATONSVILLE		9 OVERBROOK ROAD					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		9 OVERBROOK ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print)		First MINNIE	Middle C.	Lost	4 DATE OF DEATH	Month MAY 31,	Day Year 1967				
S SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B DATE OF BIRTH 1-16-1883	9 AGE (in years lost birthday) 84 yrs	F UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country)		12 CITIZEN OF WHAT COUNTRY? U.S.A.					
Wm. Frankle				Maryland							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO 220-44-5540		17. INFORMANT Mrs. Thelma Johnson, 345 Martingale Ave. Address			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary Occlusion, Acute		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH					
11x01		DUE TO		(b) Arteriosclerotic Heart Disease		Sudden					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(c)				6 mos.					
20a ACCIDENT WAS DUE TO <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour o m p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Aug. 19 63, to May 1967, 19 , that (I) (we) last saw the deceased alive on May 3 19 67, and that death occurred at 11:45A.M. from causes and on the date stated above										22b DATE SIGNED 5/31/67	
22a. SIGNATURE											
22c. PHYSICIAN'S NAME (Type)		LEO J. GAVER		22d ADDRESS		1 MALLOW HILL ROAD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-3-1967		23c. NAME OF CEMETERY OR CREMATORIALoudon Park Cemetery		23d. LOCATION (City or Town) Baltimore, Maryland (County) (State)					
24. FUNERAL DIRECTOR HOWARD H. HUBBARD		ADDRESS 4107 WILKENS AVE. 21229		25a. REC'D. BY REG. STAR DATE JUN 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 25M 1/67											



~~To HOSPITAL OR ATTENDING PHYSICIAN:~~ The law requires that the death certificate be executed within 24 hours after death.

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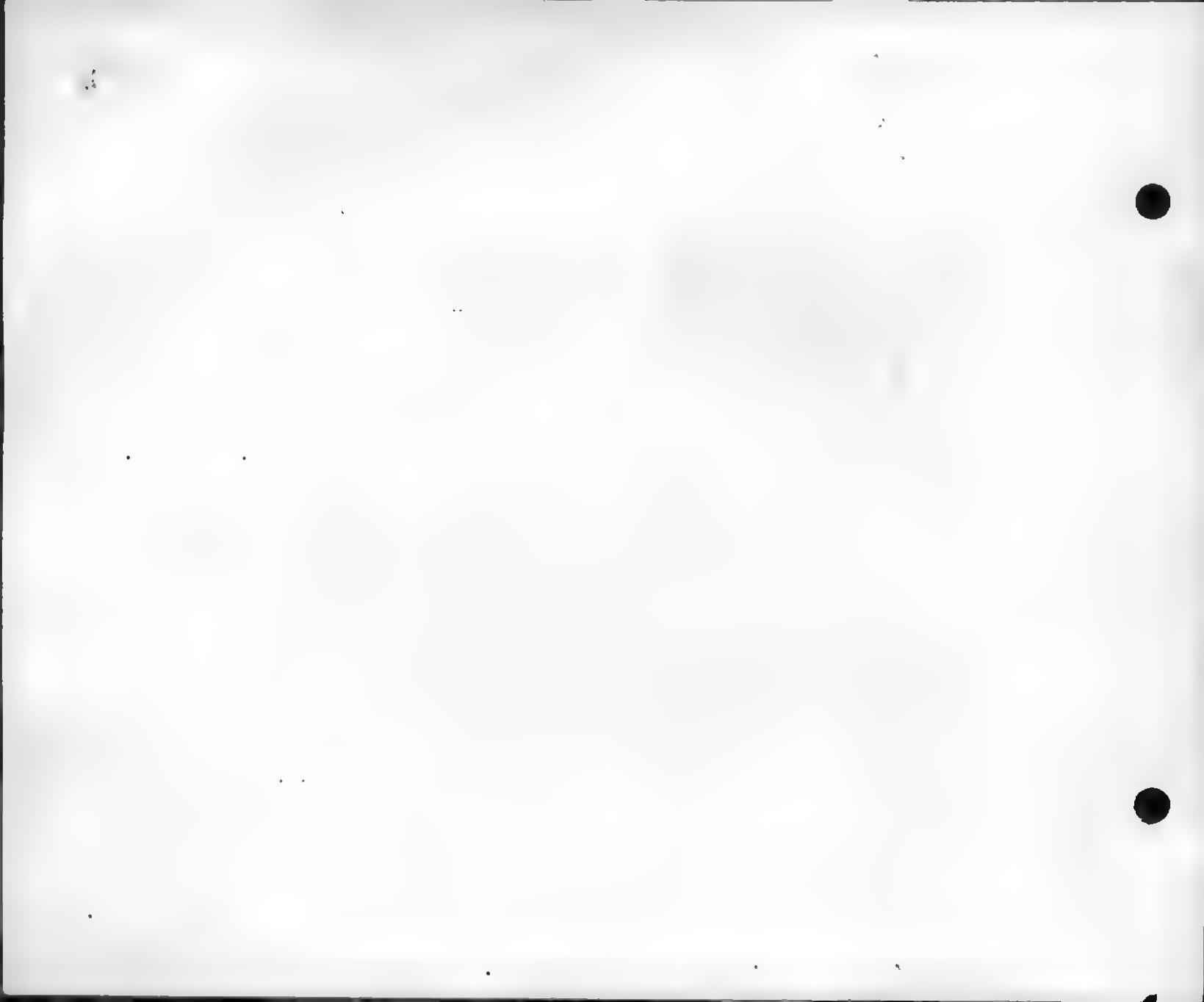
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06383

Item #8 Film #3210 6/272

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital			d. STREET ADDRESS 321 East 30th Street		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John Thomas POTEET		First	Middle	Last	4. DATE OF DEATH May 28 1967
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-28-93 91	9. AGE (in years last birthday) 75 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Maintenance retired		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Sheffield Poteet			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-18-72101	17. INFORMANT Address Mrs. Mary Poteet 321 E. 30th St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia involving the right and left lungs. HIV Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure secondary to arteriosclerotic and rheumatic heart disease. HIV (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Harford County, Md.	(County) (State)
21. I certify that (A) (this hospital) attended the deceased from May 19 1967 to May 28 1967 , that (A) (we) last saw the deceased alive on May 28 1967 , and that death occurred at 8:20 AM , from causes and on the date stated above.					
22a. SIGNATURE <i>Lawrence F. Misanik</i>		22b. DATE SIGNED May 29, 1967			
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Goodwill Church Cemetery		23d. LOCATION (City or Town) (County) (State) Harford County, Md.
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.		25a. REC'D. BY REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06384

CERTIFICATE OF DEATH

16273

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
a. COUNTY Baltimore		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 34 Dowling Circle	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Jack		4 DATE OF DEATH Month Day Year May 31, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. OCCUPATION (Give kind of work done during most of work pg. life, even if retired) Mrs. Artisan Flooring		10. KIND OF BUSINESS OR INDUSTRY Mrs. retail Inst.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Powell		14. MOTHER'S MAIDEN NAME Blanche Aban	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 215-18-8863	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary edema DUE TO congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inoperable carcinoma of the lung DUE TO (c) Arteriosclerosis.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 6, 1967 , to May 31, 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 31, 1967 , and that death occurred at 7:30AM , from causes and on the date stated above.			
22a. SIGNATURE Roberto Ferrer		22b. DATE SIGNED May 31, 1967	
22c. PHYSICIAN'S NAME (Type) Roberto Ferrer, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Aerial		23b. DATE THEREOF 6/3/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Balt.	
24. FUNERAL DIRECTOR John Burns Sons		25a. REC'D BY REGISTRAR DATE JUN 5 1967	
		25b. REGISTRAR'S SIGNATURE Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15
96385

CERTIFICATE OF DEATH

MS.274

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN lb 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 6123 FAIRIS ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Frances Vernon Preston	First F	Middle Vernon	Last Preston
4. DATE OF DEATH MAY 15 1967	Month MAY	Doy 15	Year 1967
5. SEX M	6. COLOR OR RACE CAY	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/84
9. AGE (in years last birthday) 82	10. IF UNDER 1 YEAR Months 82	11. IF UNDER 24 HRS Days 82	12. IF UNDER 24 HRS Hours 82
10. IF UNDER 24 HRS Min 82	11. BIRTHPLACE (County & State, or foreign country) BALTIMORE CO. MD.	12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Charles Preston	14. MOTHER'S MAIDEN NAME Hildt	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK.	16. SOCIAL SECURITY NO 21705-9823	17. INFORMANT Patients chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) respiratory arrest DUE TO ASCV D		INTERVAL BETWEEN ONSET AND DEATH 2 mins.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)		3 days under.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) (None)
20f. (City or town) (None)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-13 , 19 67 to 5-15 , 19 67 that (I) (we) last saw the deceased alive on 5-15 , 19 67 , and that death occurred at 828 P.M. from causes and on the date stated above.			
22a. SIGNATURE V.R. Batson		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 5-15-67
22c. PHYSICIAN'S NAME (Type) V.R. BATSON		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/18/67	23c. NAME OF CEMETERY OR CREMATORIAL PROSPECT HILL	23d. LOCATION (City or Town) (County) (State) TOWSON BALTO. MD.
24. FUNERAL DIRECTOR John Burns Sons	ADDRESS 610 1/2 York Rd.	25a. REC'D BY REGISTRAR MAY 22 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 25M 1/67			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

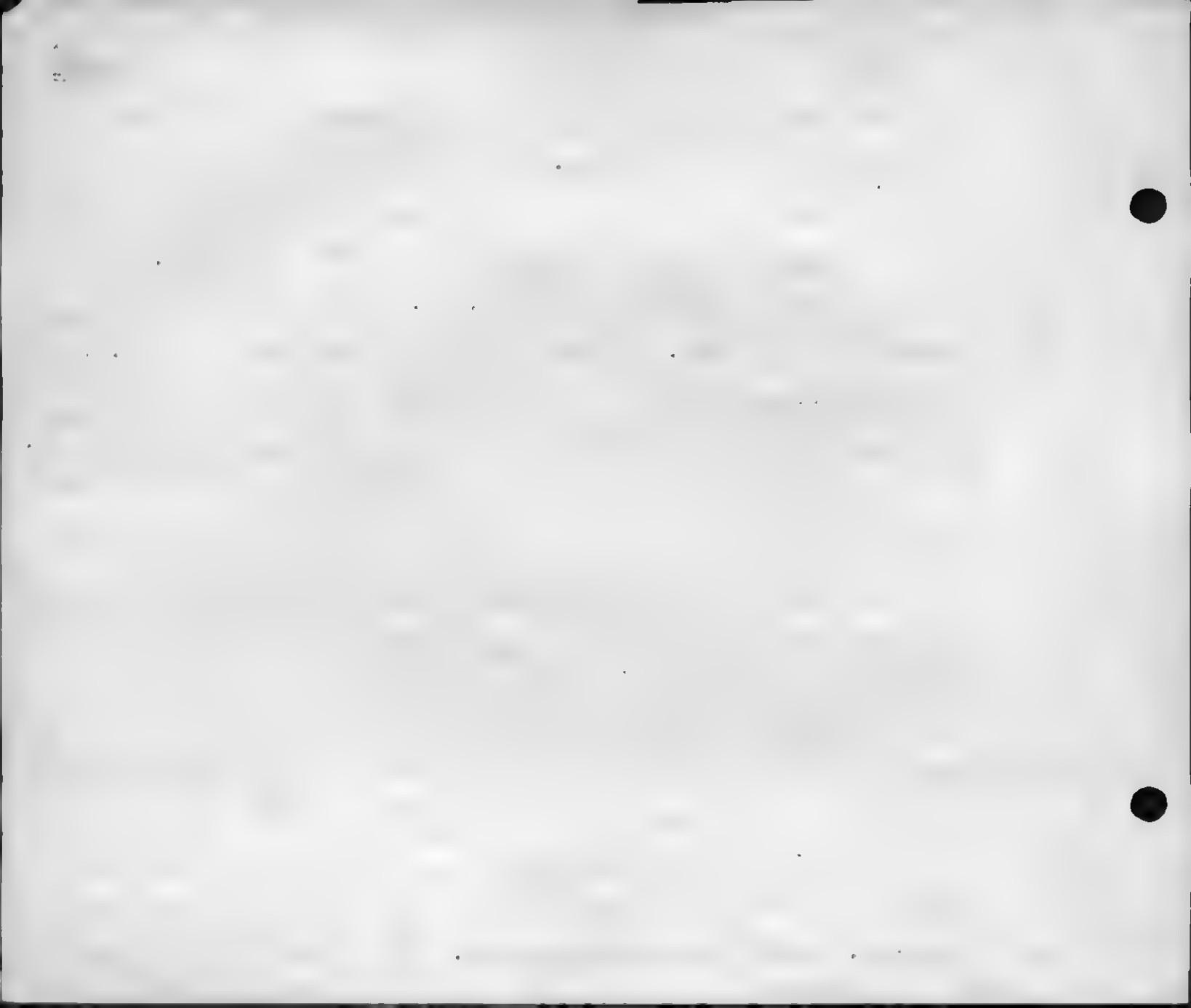
OC386

CERTIFICATE OF DEATH

16375

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If you are retained by the hospital or attending physician, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if an embalmer, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix		b. COUNTY Baltimore	
c. LENGTH OF STAY IN IB 98 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cooper Road		d. STREET ADDRESS Cooper Road	
3. NAME OF DECEASED (Type or print) Charles Marion Price		4. DATE OF DEATH Month Day Year May 20, 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1869	
9. AGE (In years last birthday) 98 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (County & State, or foreign country) Phoenix, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Oliver Price		14. MOTHER'S MAIDEN NAME Elenor Royston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-54-6542	
17. INFORMANT Mrs. Elenor P. Shepperd		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral vascular accident	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cerebrovascular Disease		DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) July 1967		20f. (City or town) (County) (State) May 20, 1967	
21. I certify that (I) (this hospital) attended the deceased from July 1967 to May 20, 1967 , that (I) (we) last saw the deceased alive on May 17, 1967 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.			
22e. SIGNATURE James F. White Jr. M.D.		M.D.	
22f. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. James F. White Jr. M.D.		22g. DATE SIGNED 5-20-67	
22h. ADDRESS Jarrettsville, Md. 21084			
23b. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL Clynnmalira	
23d. LOCATION (City, town or county) Monkton, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz		25b. REC'D. BY REGISTRAR DATE Charles Judge	
ADDRESS Jarrettsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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06386

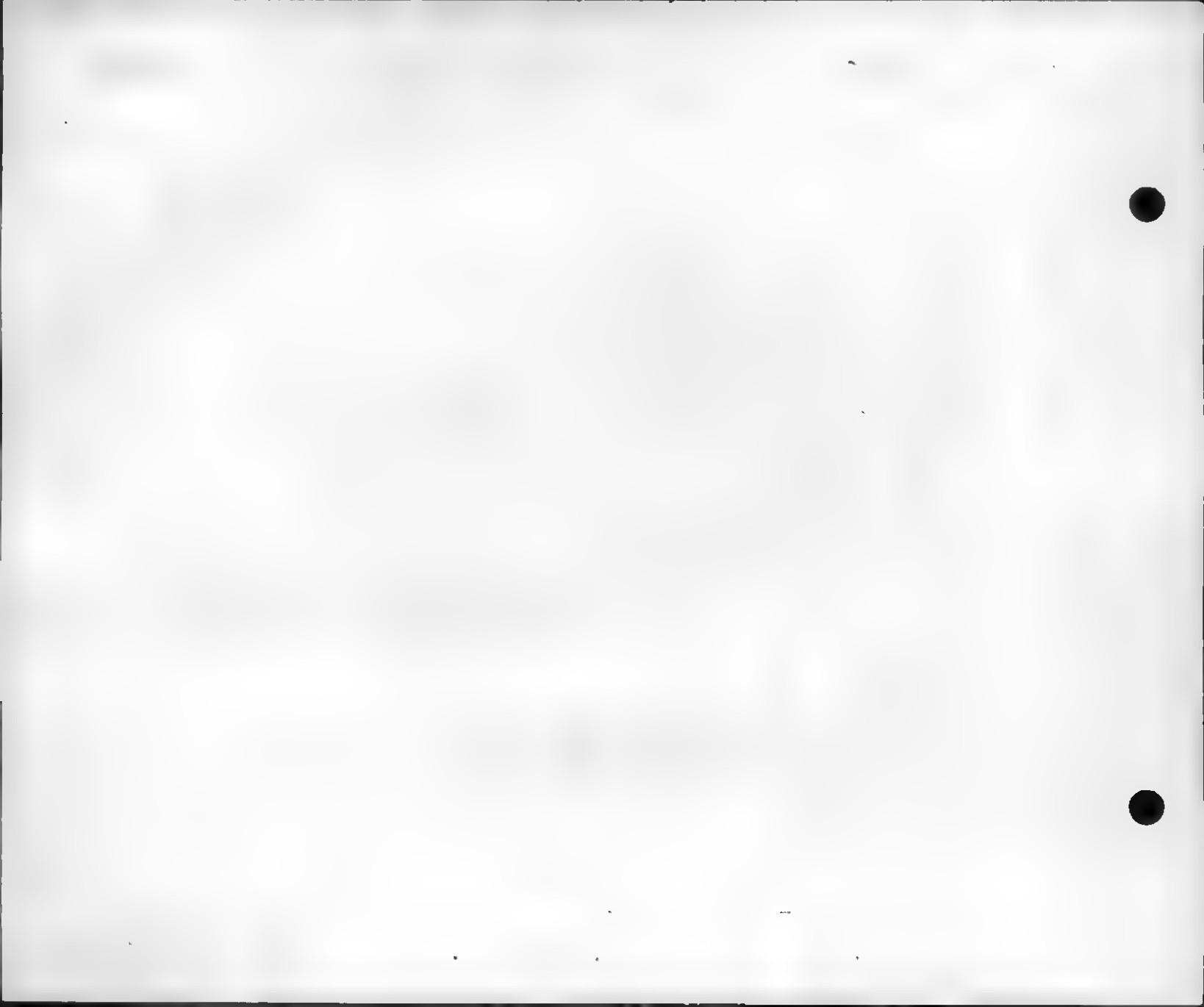
CERTIFICATE OF DEATH

36377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the back of transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, if institut. or Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oliver 1722			c. LENGTH OF STAY IN 1b 5 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 403 New Pittsburgh Ave.			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oliver 1722, Md.		
3. NAME OF DECEASED (Type or print) Henry Osborne Pryor			4. DATE OF DEATH May 24, 1967	Month	Day
S. SEX Male	6. COLOR OR RACE Col	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1892	9. AGE (In years lost birthday) 74 yrs	10. IF UNDER 1 YEAR Months 8 Days 18 Hours - Minutes -
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Coal Operator			10b. KIND OF BUSINESS OR INDUSTRY Ship Yards	11. BIRTHPLACE (County & State, or foreign country) Keysville, Va.	
13. FATHER'S NAME Samuel Pryor			14. MOTHER'S MAIDEN NAME Virginia Green		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO 213-07-4191	17. INFORMANT Storage Pryor 301 Pine St.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. -IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Anterio se/ensis					
INTERVAL BETWEEN ONSET AND DEATH 1 day					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1950 to May 24, 1967 , that (I) (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 3 PM , from causes and on the date stated above.					
22a. SIGNATURE William C. Wade			22b. DATE SIGNED May 24, 1967		
22c. PHYSICIAN'S NAME (Type) William C. Wade, M.D.			22d. ADDRESS 140 Oak Avenue, Oliver 1722, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-27-67	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County) (State)
24. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave., Balto., Md.			ADDRESS	25a. REC'D. BY REGISTRAR WMA 24 1867	25b. REGISTRAR'S SIGNATURE Charles R. Law
VR A15 (4) 25M 1/67					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06387

CERTIFICATE OF DEATH

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1 PLACE OF DEATH o. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
				o. STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN fb		b. COUNTY	
				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		d. STREET ADDRESS 200 Mallow Hill Rd.		e. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mary		Middle E. Brown	Last Raley	4 DATE OF DEATH Month May	Doy Year 23 1967
S SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/92	9 AGE (In years last birthday) 75 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Freeland, Md.	
13. FATHER'S NAME ----- Brown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 220-24-1273		17. INFORMANT Edward Kaplitz Address 4603 Wilkens Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) <u>arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last (b) <u>Diabetes</u> (c) <u>Hypertension</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 12</u> , 1962, to <u>May 23</u> , 1967, that (I) (we) last saw the deceased alive on <u>May 22</u> 1967, and that death occurred at <u>5:00 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Harry L. Knipp</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>5-23-67</u>
22c. PHYSICIAN'S NAME (Type) Dr. Harry Knipp		22d. ADDRESS 4116 Edmondson Ave. <u>21229</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/67		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229		25a. RECD BY REGISTRAR DATE MAY 25 1967	25b. REG. STRR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06389

CERTIFICATE OF DEATH

1. NAME OF RELEASED
(Type or Print)
Clinton Lang Reckord

2. DATE AND HOUR OF DEATH
May 9, 1967

982782 P.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

Baltimore County

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

Johnson 4
St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE

B. COUNTY

Maryland

Hanford

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Bel Air

D. STREET ADDRESS (If rural, give location)

163 North Williams Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Oct. 18, 1886

9. AGE (In years
last birthday)

80

If Under 1 Yr.
Months: Days Hours
Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auditor

10B. KIND OF BUSINESS OR INDUSTRY

RACE TRACK

13. FATHER'S NAME

John Reckord

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or Unknown) If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

432-01-0241

14. MOTHER'S MAIDEN NAME

Lydia A. Zimmerman

17. INFORMANT (W.R.) 838-7117

Mrs. Isabel O'C. Reckord

ADDRESS

**163 N. Williams St.
Bel Air, Maryland 21014**

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary Insufficiency

Acute

(B) DUE TO

Arterio-sclerotic heart disease

3 yrs.

(C) _____

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION first.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CALLING IT

22. I certify that (I) (this hospital) attended the deceased from **July 19 64** to **May 9, 19 67**.
that (I) (we) last saw the deceased alive on **May 9 19 67** and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. Edward Leach

M.D. Attending Phys.

Med. Director Staff Phys.

23B. DATE SIGNED

5-10-67

23C. PHYSICIAN'S NAME (Type)

C. Edward Leach

M.D.

23D. ADDRESS

14 E. Eager St.

Baltimore, Md.

(City, town, or county)

(State)

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

May 12, 1967

24C. NAME OF CEMETERY or CREMATORIUM

Mountain Christian Church Cem.

24D. LOCATION

Joppa, Hanford Co., Maryland

(City, town, or county)

(State)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dent of Health, or the funeral director, or the hospital.

VR A15 (4)
25M 1/67

25A. DATE REC'D BY HEALTH DEPT.

AMOUNT RECEIVED

MAY 16 1967

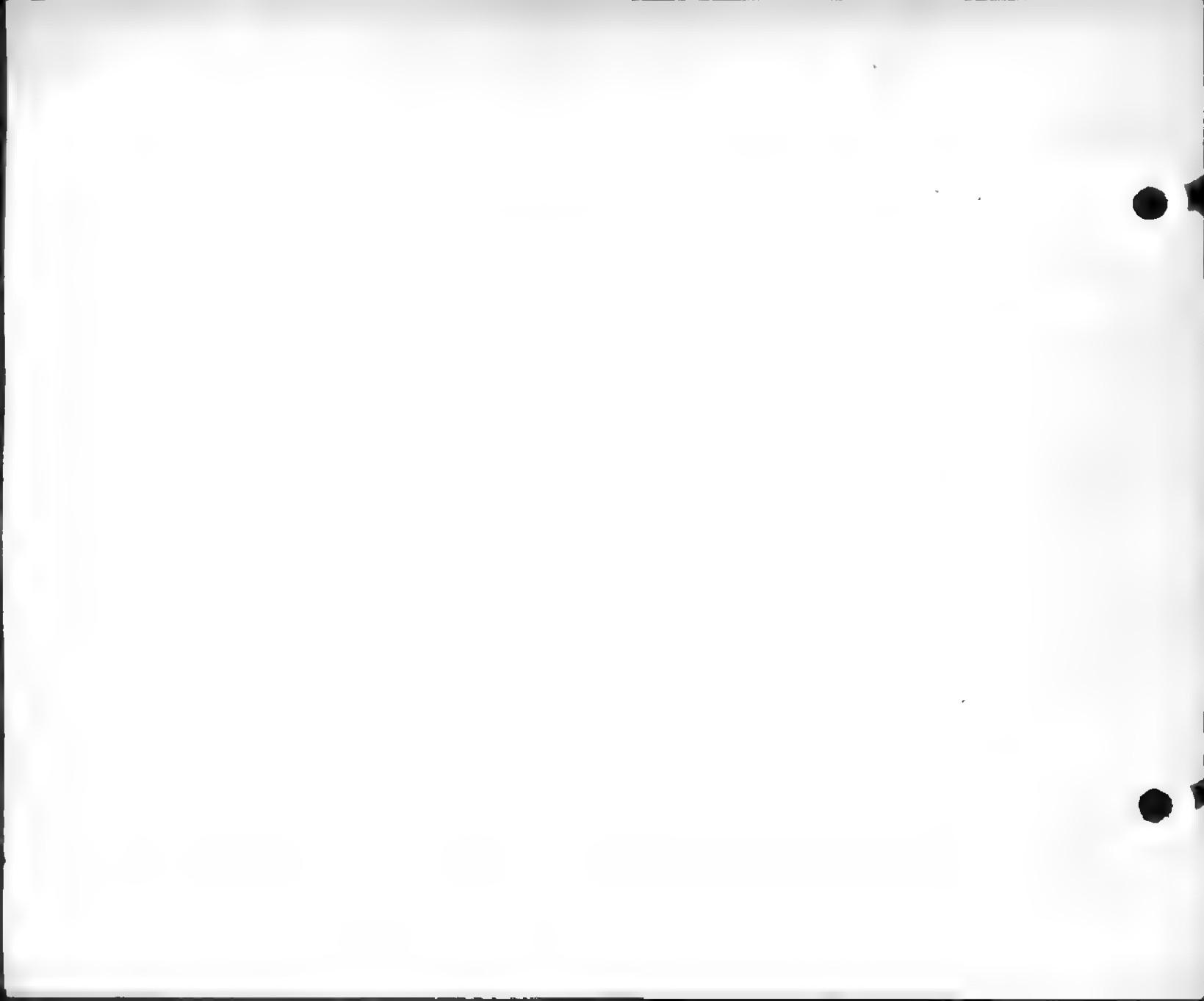
Charles Judge

25C. FUNERAL DIRECTOR

Joseph William Foster

ADDRESS

**w. Broadway & Williams St.
Bel Air, Maryland 21014**

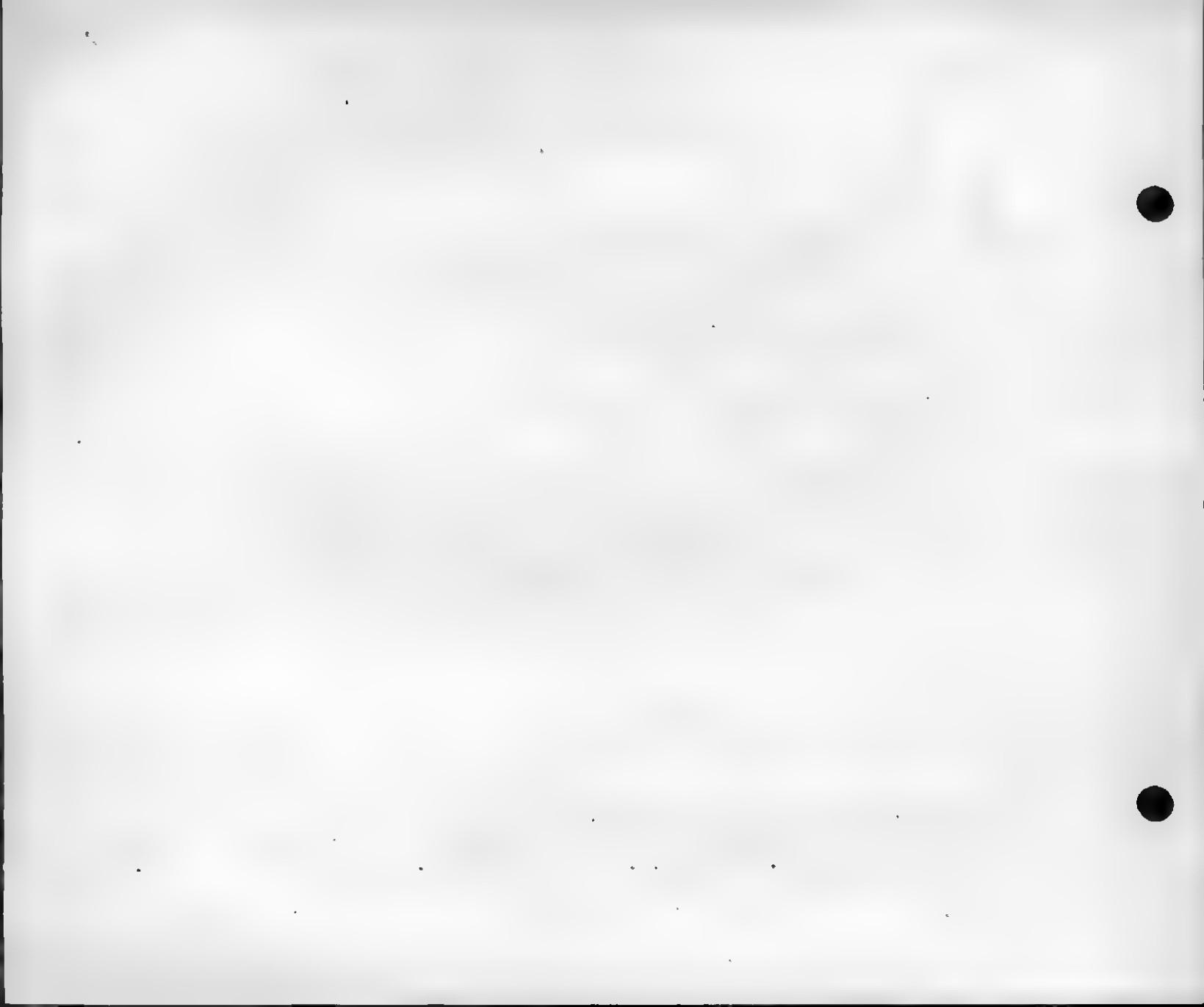


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 15778

1. PLACE OF DEATH o COUNTY <i>Balto.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Balto.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN lb <i>20 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Notre Dame Motherhouse</i>		d. STREET ADDRESS <i>3206 Wylie Ave.</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Egwing</i>	Middle <i>Sr. Mary</i>	Last <i>Reich</i>	4. DATE OF DEATH Month <i>May</i>	Day Year <i>11 1967</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 26, 1882</i>	9. AGE (in years last birthday) <i>84 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Religious</i>		11. BIRTHPLACE (State or foreign country) <i>Prussia</i>		12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>		
13. FATHER'S NAME <i>Reich, Anthony</i>		14. MOTHER'S MAIDEN NAME <i>Blum, Anna</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>218-34-3692</i>		17. INFORMANT <i>JL Sr. M. Ernest</i>		Address <i>6401 N. Charles St.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infective Ca</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Primary Site Not Determined</i> (c) <i>ASCVD</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>11 - 9</i> , 19 <i>66</i> , to <i>5 - 11</i> , 19 <i>67</i> , that I last saw the deceased alive on <i>5 - 10</i> , 19 <i>67</i> , and that death occurred at <i>11:55 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>Robert J. Makowski</i>								
PHYSICIAN'S NAME (Type) <i>Robert J. Makowski, M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 15, 1967</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Sisters Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Arm, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond J. Currah 817 Scarlett Dr. Towson, Md.								
ADDRESS 24a. REC'D BY REGISTRAR DATE <i>MAY 22 1987</i> <i>Charles Judge</i>								



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96391

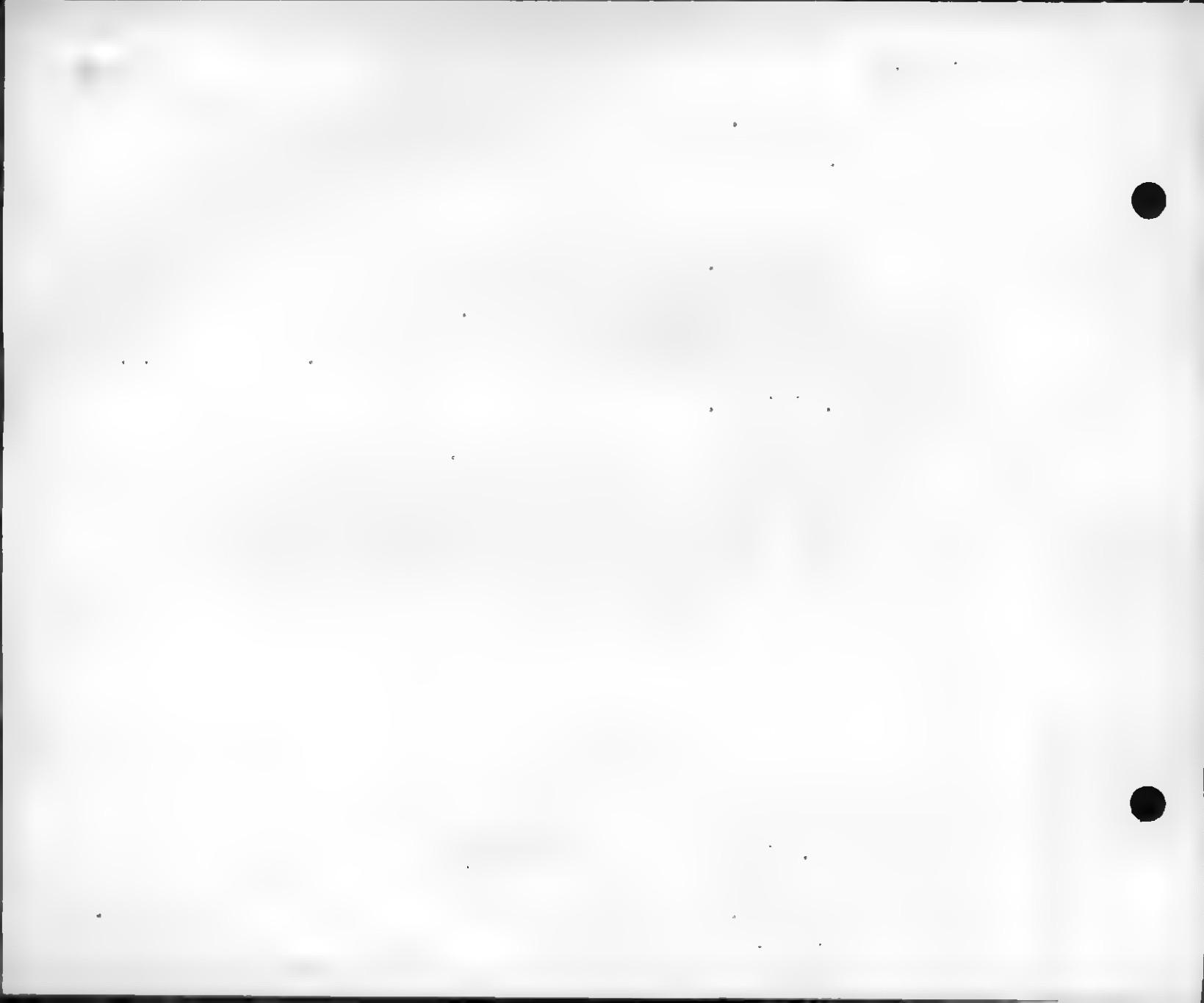
CERTIFICATE OF DEATH

10050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton Rural	c. LENGTH OF STAY IN lb Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton Rural				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7909 Belair Road		d. STREET ADDRESS 7909 Belair Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED Louisa A. Reider	First	Middle	Lost			
4. DATE OF DEATH May 8 1967	Month	Day	Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1907	9. AGE (In years last birthday) 59 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Baltimore Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George A. Klein Sr.			14. MOTHER'S MAIDEN NAME Annie Brockmeyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO None	17. INFORMANT John H. Reider	Address 7909 Belair Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1978			INTERVAL BETWEEN ONSET AND DEATH Metastatic cancer, rib, liver, Spleen			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO (b) undefined primary co- underlying or breast? 1 yr?			
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May 6		20f. (City or town) Overlea	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 5 to May 8, 1967, that (I) (we) last saw the deceased alive on May 8, 1967, and that death occurred at 7A.M., from causes and on the date stated above.						22b. DATE SIGNED
22c. SIGNATURE Dr. Riger		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Overlea Avenue			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 12, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith		23d. LOCATION (City or Town) Kenwood	(County) (State) Balto. Md.
24. FUNERAL DIRECTOR Lassahn Funeral Home			ADDRESS 7401 Belair Road		25a. REC'D BY REGISTRAR MAY 12 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06392

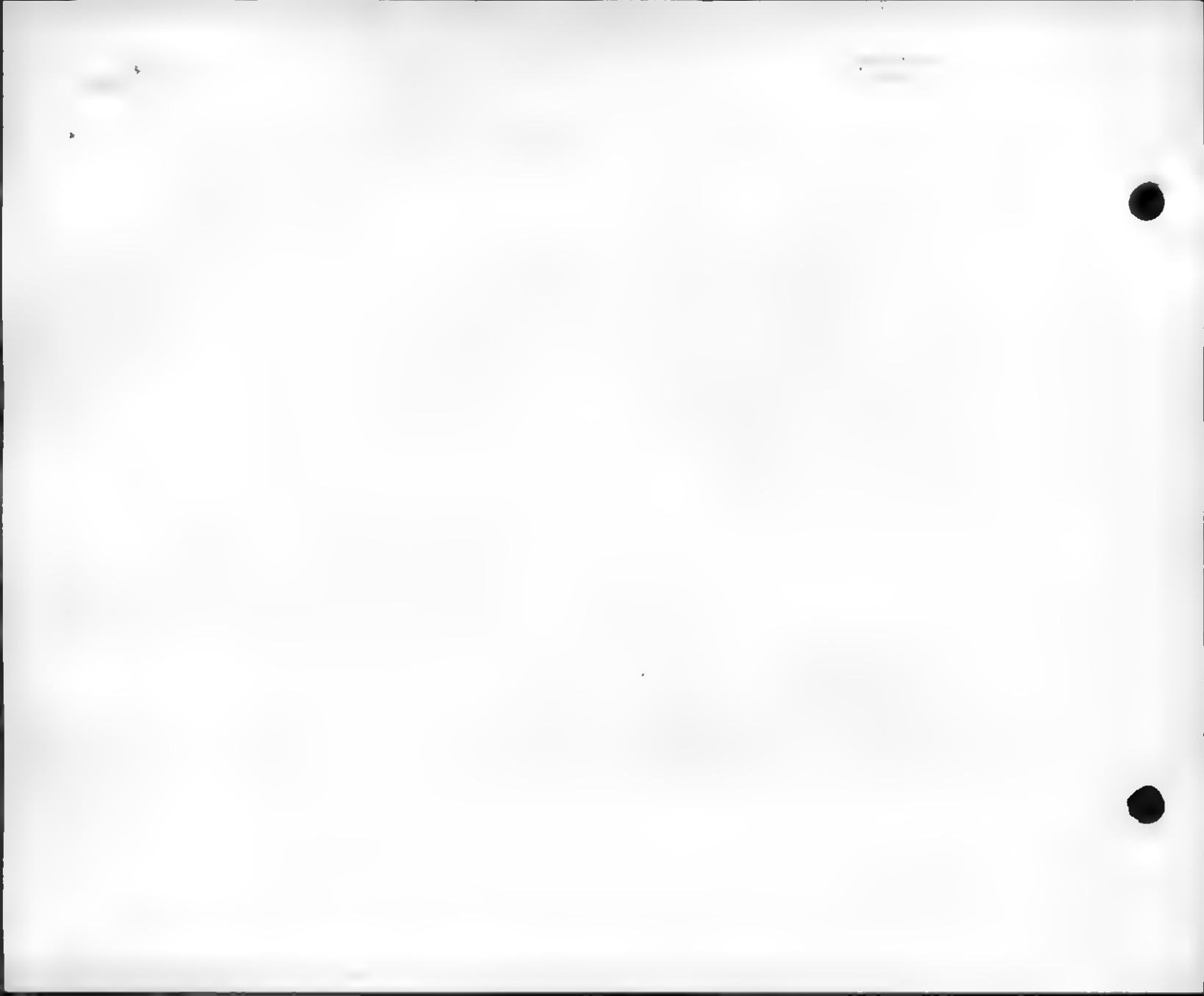
CERTIFICATE OF DEATH

JE 381

10 HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 14 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 6102 Hamilton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Joseph		First	Middle	Last	4. DATE OF DEATH Reihl, Jr. May 20, 1967	Month	Day	Year						
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 20, 1967	9. AGE (In years since birthday) yrs	IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min 0							
10a USL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY USA								
13. FATHER'S NAME Joseph Frederick Reihl, Sr.		14. MOTHER'S MAIDEN NAME Norma Helen Massey		Address										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO none		17. INFORMANT Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 29 hours					
20a MEDICAL CERTIFICATE ON		20b PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20c		20d			20e	20f	20g	20h		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		20c. TIME OF INJURY Month, Day, Year Hour: o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(City or town) May 20, 1967		(County) May 22, 1967	(State) May 22, 1967
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20, 1967 , to May 22, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 22, 1967 , and that death occurred at 2:35 P.M. , from causes and on the date stated above.		22a. SIGNATURE <i>Imelda Salanio</i>		M.D. ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED May 22, 1967				
22c. PHYSICIAN'S NAME (Type) Imelda Salanio, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/67		23c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel Cem.		23d. LOCATION (City or Town) (County) (State) Rock Hall, Md.				
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR MAY 25 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

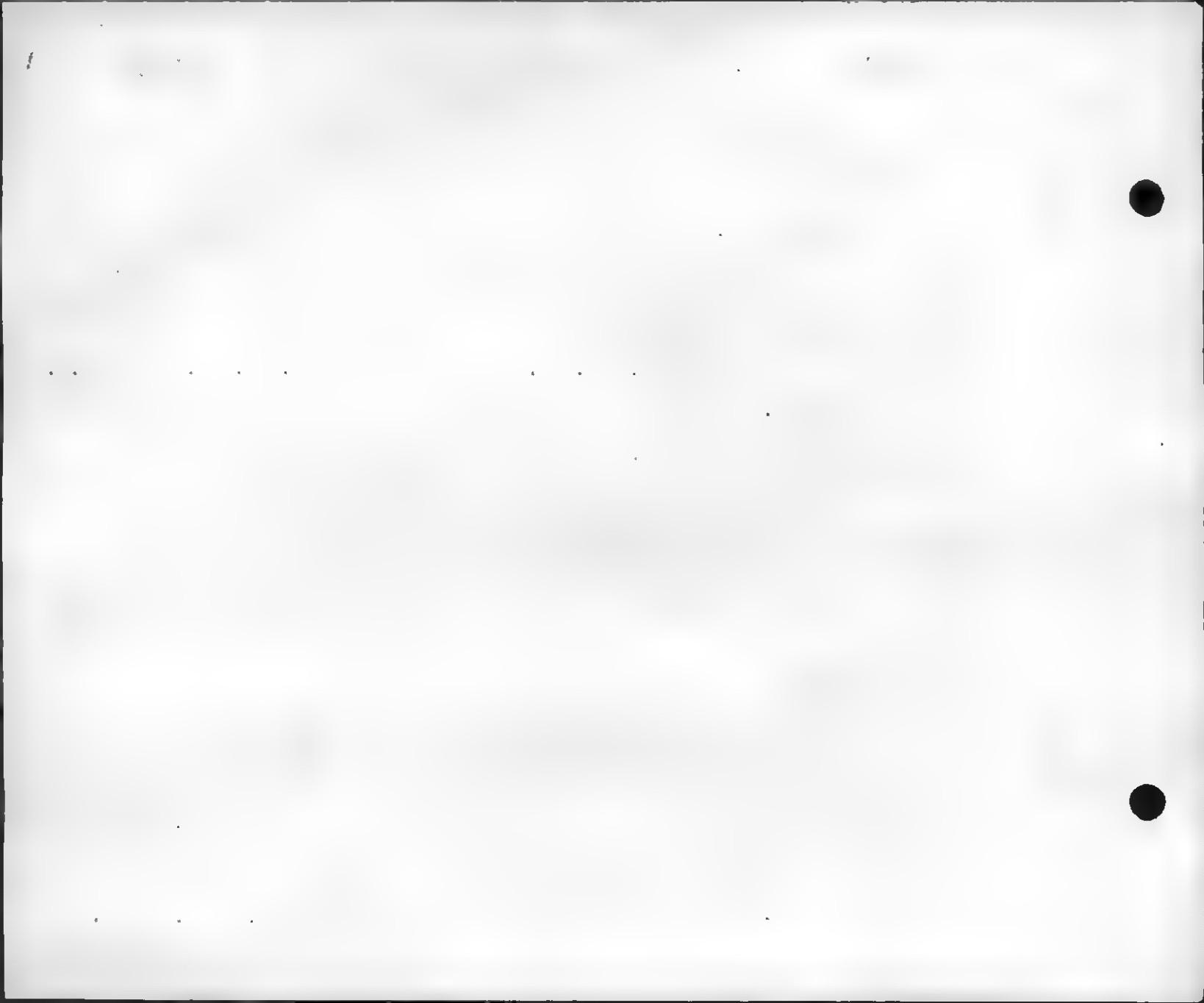
96393

CERTIFICATE OF DEATH

JF382

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. **Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.**

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b 25 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4544 Ridge Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
3. NAME OF DECEASED (Type or print) Margaret		d. STREET ADDRESS 4544 Ridge Road 36	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Thau Mfg. Co.	
13. FATHER'S NAME Henry H. Deigert		11. BIRTHPLACE (County & State, or foreign country) Fullerton Balt. Co. Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-20-9375A	
17. INFORMANT Mrs Gladys Schaefer		18. ADDRESS 1815 Wycliffe Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 3 days.	
Coma - Stroke - Atherosclerotic Cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-13-, 1966, to 6 May, 1967 that (I) (we) last saw the deceased alive on 6 May, 1967, and that death occurred at 10 p.m. M, fram causes and on the date stated above.			
22a. SIGNATURE John C. Hyde		22b. DATE SIGNED 5-8-67	
22c. PHYSICIAN'S NAME (Type) J 614 N E. Hyde		22d. ADDRESS 7527 Belair Rd Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-9-1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 2401 Belair Road		25a. REC'D BY REGISTRAR 36	25b. REGISTRAR'S SIGNATURE Charles J. Judge
		DATE MAY 11 1967	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06394

CERTIFICATE OF DEATH

Reg. Dist. No. 10383

1. PLACE OF DEATH a. COUNTY <i>BALTO.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>144</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PARKVILLE</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PARKVILLE</i>		d. STREET ADDRESS <i>3101 TEXAS AVE.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3101 TEXAS AVE.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>HELEN</i>	Middle <i>Sylvia</i>	Last <i>REYNOLDS</i>	4. DATE OF DEATH <i>MAY 24 1967</i>	Month <i>MAY</i>	Day <i>24</i>	Year <i>1967</i>	
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APRIL 1, 1898</i>	9. AGE (In years lost birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WORK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT home</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>WILLIAM FINCK</i>		14. MOTHER'S MAIDEN NAME <i>CATHERINE HAMMEL</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No.</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>FAMILY</i>		Address <i>SAME</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1941</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>metastatic carcinoma</i>		<i>metastatic carcinoma</i>							
{ (b) DUE TO (c) <i>per abdominal surgical removal of breast skin</i>		<i>24yrs.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>5/18/67</i> , to <i>5/22/67</i> , that I last saw the deceased alive on <i>5/22/67</i> , and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1250 E. North Ave.</i> DATE SIGNED <i>5/26/67</i>							
ACTUAL SIGNATURE <i>Sol Tanenbaum</i>		PHYSICIAN'S NAME (Type) <i>Dr. Sol Tanenbaum</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-27-1967</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood</i>		22d. LOCATION (City, town, or county) (State) <i>Taylor Ave. BALTO., Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Walter Conklin</i>		ADDRESS <i>5444 BELAIR RD.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 29 1967</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06395

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)	
				a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1D		b. COUNTY	
Catoonsville		5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		SPRING GROVE STATE HOSPITAL		Baltimore	
e. IS RESIDENCE ON A FARM?					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
	William	J	Riggs	May	9 19 67
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 24, 1913	53 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
chauffer				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John F. Riggs		Bessie Kane		U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		Address	
		220-07-5216		Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bronchogenic carcinoma of the lungs with metastatic lesions			
6/21 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 4, 1967, to May 9, 1967, that <input type="checkbox"/> (we) last saw the deceased alive on May 9, 1967, and that death occurred at 11:00 M, from the causes and on the date stated above.		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. SIGNATURE <i>Stella Wachsler</i>		p. 22b. DATE SIGNED 5-10-67			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 15/13/67		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229		23d. LOCATION (City, town or county) Baltimore, Maryland	
				25a. REC'D BY REGISTRAR MAY 11 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Pg. 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
Item #14 Film #1407 PC CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			c. LENGTH OF STAY IN 1b 25 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			d. STREET ADDRESS 3017 Edgewood ave				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3017 Edgewood ave		e. 5. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Henry D. Riley		First		Middle		Last		4. DATE OF DEATH May 6, 1967		Month	Day	Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 26 1903		9. AGE (In years 63 last birthday) 63 yrs		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days		Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker			10b. KIND OF BUSINESS OR INDUSTRY Guest Home			11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William H. Riley			14. MOTHER'S MAIDEN NAME Sarah E. Riley			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No			16. SOCIAL SECURITY NO. 220-01-9492 17. INFORMANT Family Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO <i>Bronchogenic Carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <i>Atherosclerotic Cardiac Lesions Disease</i> (c)						INTERVAL BETWEEN ONSET AND DEATH 1 yr + ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 2-1, 1966, to 5-6, 1967, that (I) (we) last saw the deceased alive on 5-6 1967, and that death occurred at 3y M, from causes and on the date stated above.									22b. DATE SIGNED 5-8-67				
22a. SIGNATURE <i>John C. Hyle</i>						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22d. ADDRESS 7527 Belair Road				
22c. PHYSICIAN'S NAME (Type) John C. Hyle MD		23b. DATE THEREOF 5/10/67			23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) Towson		(County) Balto.		(State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/10/67			23c. NAME OF CEMETERY OR CREMATORIALy Dulaney Valley Mem.		23d. LOCATION (City or Town) Towson		(County) Balto.		(State)		
24. FUNERAL DIRECTOR C.F. EVANS & SON		8802 ADDRESS Harford road			25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						
VR A15 (4) 25M 1/67													



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

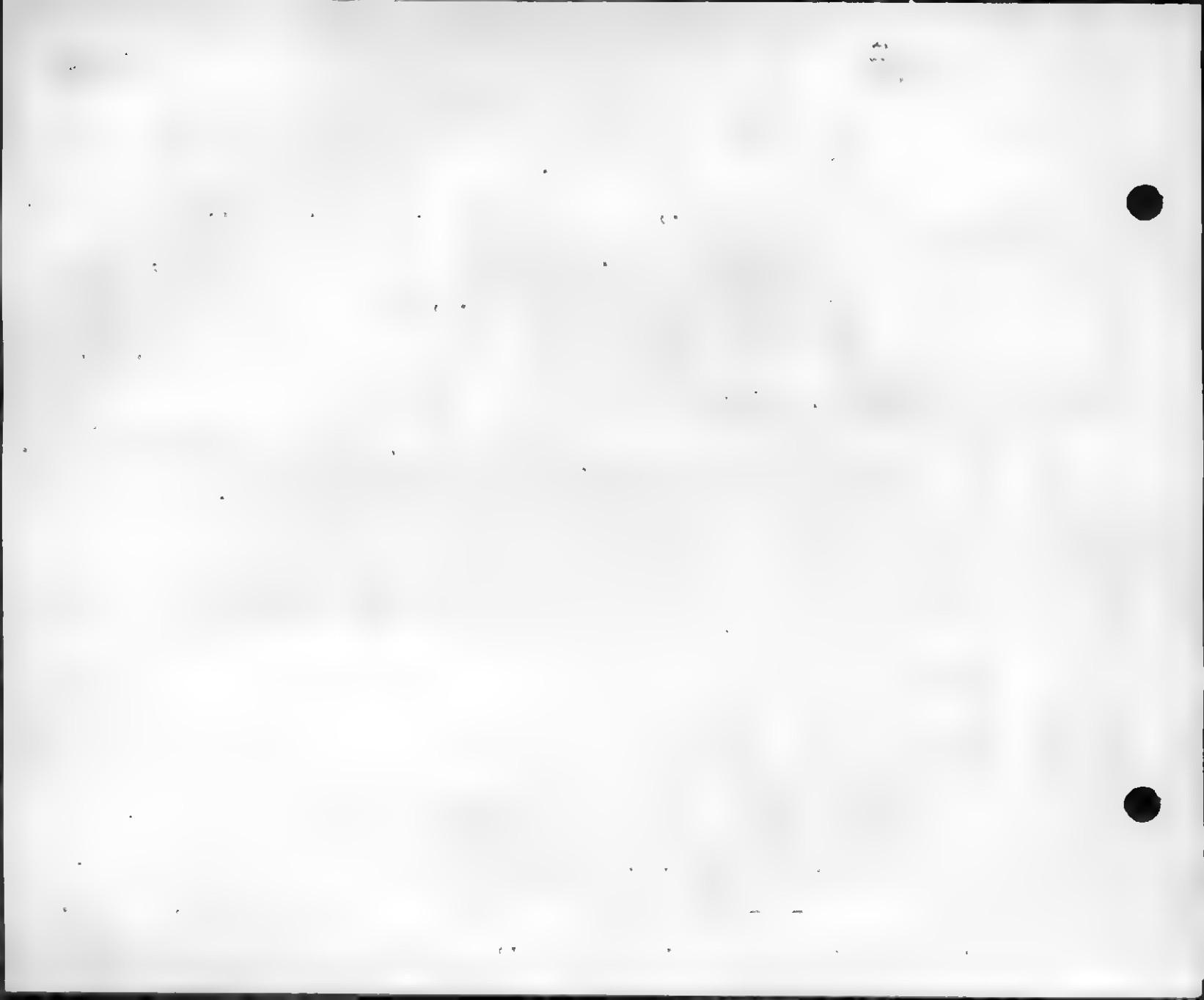
26397

18396

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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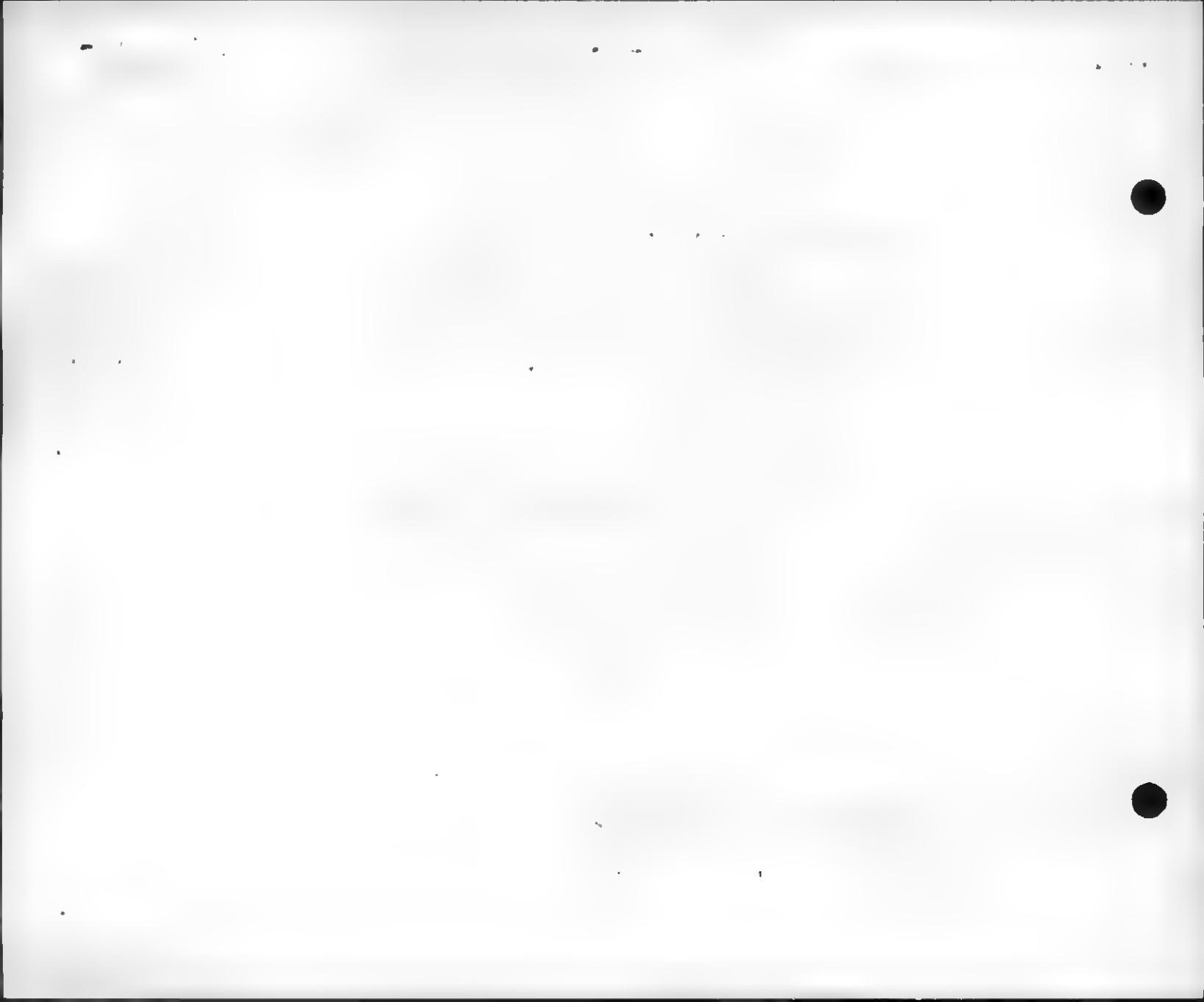
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY	
Baltimore MARYLAND		Maryland Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Catonsville	30 Yrs.	Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
102 Bloomsbury Ave.,			
3. NAME OF DECEASED (Type or print)	First Irene	Middle M.	Last Ring
4. DATE DF DEATH	Month May	Day 25,	Year 1967
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 1, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	
Housewife	At Home	Md.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Stephen J. Anderson	Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no			(12) Virginia A. Nonemacher 521 Windwood Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Peptic ulcer - diverticulitis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from December 6, 1950, to May 25, 1967, that (I) (we) last saw the deceased alive on May 8, 1967, and that death occurred at 6 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>John A. Nesbitt Jr., M.D.</i>	22b. DATE SIGNED M.D. ATTENDING MED. DIRECTOR STAFF PHYS. <i>5-25-67</i>		
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS 1009 Frederick Road, Baltimore, Md.		
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIALy	23d. LOCATION (City, town or county) (State)
Burial	5-29-1967	Loudon Park	Baltimore, Md.
24. FUNERAL DIRECTOR	ADDRESS G. Howard Strong 3207 W. North Ave.,		25a. REC'D BY REGISTRAR MAY 29, 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE
HEALTH DEPT.

1 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #857757 pg. 10287
1. PLACE OF DEATH
a. COUNTY
Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fork c. LENGTH OF STAY IN lb
35 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Harford Road Fork, Md.

MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fork			c. LENGTH OF STAY IN lb 35 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fork			d. STREET ADDRESS Robert's Fruit Stand		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Road Fork, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First FRANCES	Middle MARY	Last ROBERTS	4. DATE OF DEATH 5 12 1967	Month 5	Day 12	Year 1967	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min	
S SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-16-1909	9 AGE (In years 57 last birthday) 58/7 yrs						
10b USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress			10b KIND OF BUSINESS OR INDUSTRY Bendix Co.			11 BIRTHPLACE (State or foreign country) New York			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME O'Donnell						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 213-169626			17. INFORMANT Mr Walter Roberts Box 25 Kingsville, Md.			Address 21087		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)											
INTERVAL BETWEEN ONSET AND DEATH											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) Bel Air		(County) Md.	(State) Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D.											
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 5-13-67									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5-16-1967		23c NAME OF CEMETERY OR CREMATORIUM Bel Air Memorial Cemetery		23d LOCATION (City or Town) Bel Air		(County) Md.		(State) Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7461 Belair Road		ADDRESS (34)		25a. REC'D BY REG STRR MAY 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06393

CERTIFICATE OF DEATH

16388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Baltimore	MARYLAND	Maryland	Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B	
Towson		Lutherville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
St. Joseph Hospital		8504 Valley Field Rd.	
3. NAME OF DECEASED (Type or print)	First Harry	Middle L.	Last Roff
4. DATE OF DEATH	Month 5	Day 23	Year 1967
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
M	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1895. 3/16/1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Post Office.		Postal.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Harry Roff.		Alice Hall.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes. War 1		17. INFORMANT	
		Address	
		Mrs. Ann Hessler, 8504 Valleyfield rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congenital heart failure	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerosis cardiovascular disease	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
Nelson S. de la Paz		5/23/67.	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS	
Nelson S. de la Paz		St. Joseph's Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial.		5/26/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)	
Leonard J. Ruck, inc. 5305 Harford Rd.		Baltimore, Md.	
24. FUNERAL DIRECTOR		25a. REC'D. BY REGISTRAR	
Leonard J. Ruck, inc. 5305 Harford Rd.		25b. REGISTRAR'S SIGNATURE	
		MAY 24 1967 Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 2 Film No. 643767 kk													
CERTIFICATE OF DEATH													
1 PLACE OF DEATH						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)							
a. COUNTY BALTIMORE MARYLAND						b. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS Dundalk Hotel				
CATONSVILLE						BALTIMORE			FOREST/HAVEN/NURSING/HOME				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOREST HAVEN NURSING HOME						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	5. UNDER 1 YEAR Months	6. UNDER 24 HRS Days	Hours	Min	
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)								
MALE	WHITE	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>		73 yrs								
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) STOREKEEPER			10b. KIND OF BUSINESS OR INDUSTRY OWN			11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME AARON ROSENFELD													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. YES W.W. I ARMY 219-01-3661A			17. INFORMANT ELIA SIDENBERG			Address				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DA/91/med-a-1725												INTERVAL BETWEEN ONSET AND DEATH	
4/22/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 12/2/67 TO MYOPENIAL DISEASE-													
DUE TO (c)													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1/1/67 to 3/14/67 , 1967, to 3/14/67 , 1967, that (I) (we) last saw the deceased alive on 3/14/67 , 1967, and that death occurred at 5800 EDMONDSON AVENUE , BALTIMORE, MARYLAND, from causes and on the date stated above.												22b. DATES GND	
22c. PHYSICIAN'S NAME (Type) DR. JOHN SHAW			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS 5800 EDMONDSON AVENUE			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Check) BURIAL-CREMA 5/16/67			23b. DATE THEREOF 5/16/67			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS LOUDEN PARK			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR TICK SOL LEVINSON & BROS. INC., 6010 REIST., RD.			25a. REC'D BY REGISTRAR MAY 22 1967			25b. REGISTRAR'S SIGNATURE J Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06401

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		b. COUNTY <i>BALTIMORE</i>		
c. LENGTH OF STAY IN 1D <i>12 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto. 12</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Dulaney Towson Nursing Home</i>				
3. NAME OF DECEASED (Type or print) <i>Jeanie McPherson</i>		First	Middle	
4. DATE OF DEATH <i>Ross 5/12/1967</i>		Last	Month Day Year	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Dec 4 1881</i>		9. AGE (in years last birthday) <i>85 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CVN HOME</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Dumbarton, Scotland</i>	
13. FATHER'S NAME <i>DUNCAN MCPherson</i>		14. MOTHER'S MAIDEN NAME <i>Jeanie McDonald</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>FAMILY RECORDS</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>C Metastases to brain</i> DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH <i>About 5 yrs</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Old age</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>May 13 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <i>—</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State) <i>—</i>
21. I certify that (I) (this hospital) attended the deceased from <i>1961</i> to <i>1967</i> , that (I) (we) last saw the deceased alive on <i>May 13 1967</i> , and that death occurred at <i>31</i> M, from the causes and on the date stated above.				22b. DATE SIGNED <i>5/15/67</i>
22a. SIGNATURE <i>Michael B. Bly</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS <i>58 w York Rd Baltimore</i>	
22c. PHYSICIAN'S NAME (Type) <i>M Paul Bly</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		
23b. DATE THEREOF <i>5/15/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>PARKWOOD CEME.</i>		
24. FUNERAL DIRECTOR <i>John Burns Sons, Towson Md.</i>		23d. LOCATION (City, town or county) (State) <i>PARKVILLE, Md.</i>		
ADDRESS <i>—</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
DATE <i>MAY 16 1967</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH															
PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <u>MARYLAND</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN lb <u>Baltimore</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7808 Brevort Rd</u>						d. STREET ADDRESS <u>7808 Brevort Rd</u>									
3. NAME OF DECEASED (Type or print)		First <u>Alma</u>		Middle <u>J.</u>		Last <u>Schaefer</u>		4. DATE OF DEATH <u>MAY 25</u>		Month	Day	Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>2-3-1913</u>		9. AGE (In years last birthday) <u>54</u>		Months	Days	Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILORING</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George J. Dolle</u>						14. MOTHER'S MAIDEN NAME <u>Kessner</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO <u>123-45-6789</u>						17. INFORMANT <u>John D Schaefer - 7807 Brevort Rd #7</u>			
Address															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>11 Glaucoma - Cataract with</u> DUE TO <u>Glaucoma - Both eyes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>None</u> DUE TO <u>Glaucoma - Both eyes</u> DUE TO <u>None</u>												INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <u>None</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>				20f. (City or town) <u>Baltimore</u>		(County) <u>Baltimore</u>	(State) <u>Md</u>
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 18</u> , 19 <u>66</u> , to <u>May 25, 1967</u> that (I) (we) last saw the deceased alive on <u>May 25, 1967</u> , and that death occurred at <u>1645</u> M, from causes and on the date stated above												22b. DATE SIGNED <u>5/27/67</u>			
22c. SIGNATURE <u>Earl L. Chambers</u>						MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22d. ADDRESS <u>4108 Liberty Hts Baltimore Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5-29-67</u>				23c. NAME OF CEMETERY OR CREMATORIUM <u>Dulaney Valley Memorial Gardens - Cockeysville, Md</u>				23d. LOCATION (City or Town) <u>Cockeysville, Md</u>			
24. FUNERAL DIRECTOR <u>Elsworth Armacost - 4400 Liberty Hts Ave</u>						ADDRESS <u>4400 Liberty Hts Ave</u>						25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

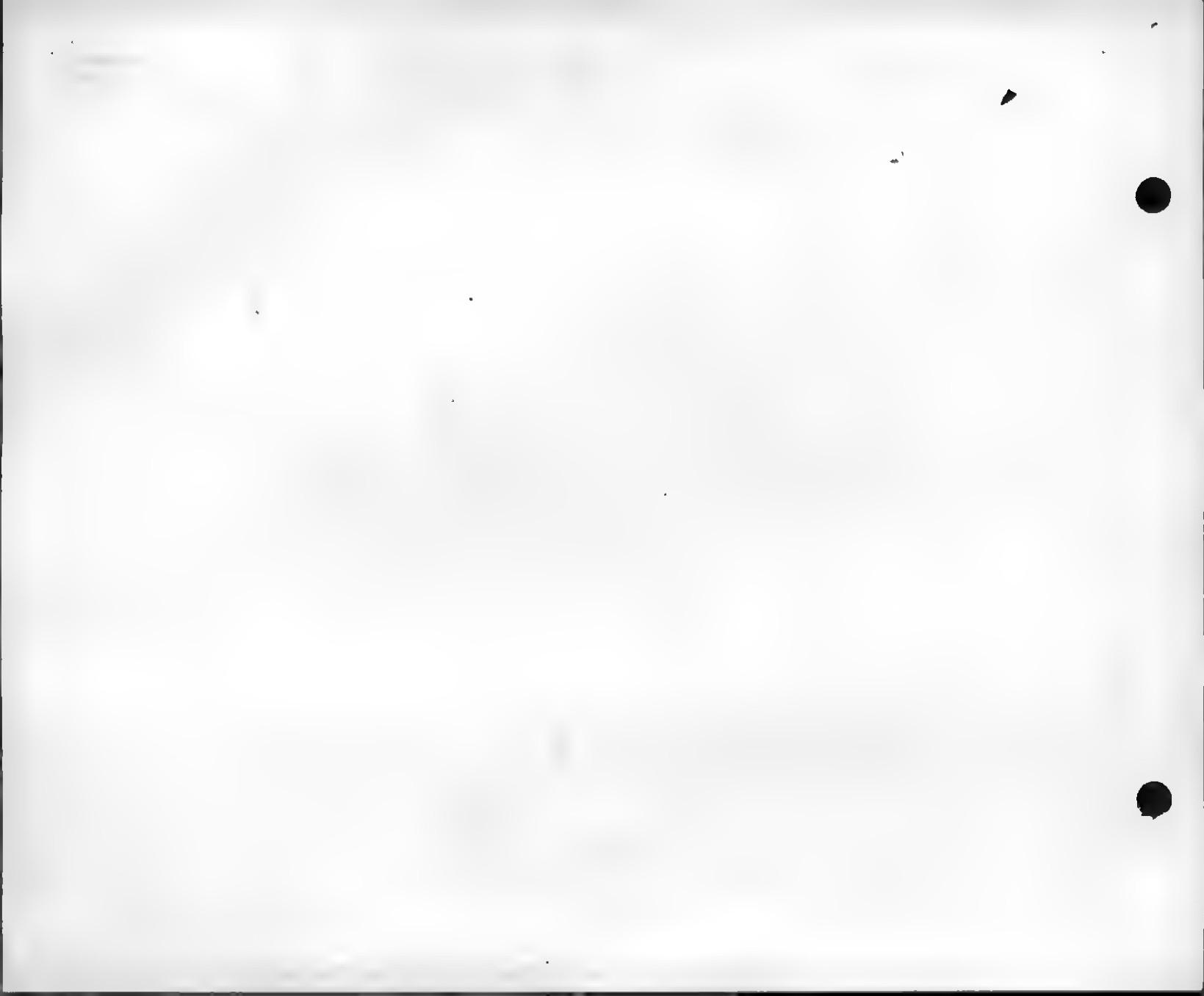
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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution give name and address before admission)	
a. COUNTY <i>Baltimore</i>		b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c. LENGTH OF STAY IN lb <i>1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore County Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
f. STREET ADDRESS <i>2721 Cylburn Ave</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>NATHAN (Norman) R. Scheer</i>		4. DATE OF DEATH Month <i>May</i> Day <i>28</i> Year <i>1967</i>	
S. SEX <i>M</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINIST</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Reuben Scheer</i>		14. MOTHER'S MAIDEN NAME <i>Pannie Karasik</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO YES WW I Army</i>		16. SOCIAL SECURITY NO. <i>212-09-8106</i>	
17. INFORMANT <i>Mrs. Betty Scheer, 2721 Cylburn Avenue</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		<i>Respiratory disease of老人.</i> DUE TO <i>Congestive heart failure</i> (b) DUE TO <i>ASCVD</i>	
		<i>12 hrs.</i> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		7 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>5-27</i> , 19 <i>67</i> to <i>5-28</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5-27-67</i> , and that death occurred at <i>8:10 AM</i> , from causes and on the date stated above.		20f. (City or town) <i>Baltimore</i> (County) <i>Maryland</i> (State) <i>MD</i>	
22a. SIGNATURE <i>George A. Papp</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <i>George A. Papp</i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <i>George A. Papp</i>
22c. PHYSICIAN'S NAME (Type) <i>George A. Papp</i>		22d. ADDRESS <i>6010 Reist Rd.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/29/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Hebron friendship</i>
24. FUNERAL DIRECTOR <i>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</i>		25a. RECEIVED BY REGISTRAR DATE <i>JUN 6 1967</i>	25b. REGISTRAR'S SIGNATURE <i>George A. Papp</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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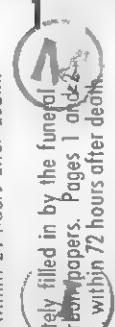
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.****TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor N. Home			e. STREET ADDRESS Lutherville		
f. ADDRESS Towson			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Frederick William Scheller			First	Middle	4 DATE OF DEATH Month Day Year May 31, 1967
5 SEX M	6 COLOR OR RACE Cauc.	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. AGE (in years last birthday) 80 yrs
10a. U.S. & AL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor, C.&P. Telephone Co.			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frederick William Scheller			14. MOTHER'S MAIDEN NAME Margaret E. Wilson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 212 05 0612		
17. INFORMANT Mrs. Mary Harvey, Lutherville, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> 4821 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)		
19. INTERVAL BETWEEN ONSET AND DEATH 10 yrs					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 1960, to 1967, that (I) (we) lost saw the deceased alive on May 1967, and that death occurred on 5/31/67 P.M. from causes and on the date stated above.					
22a. SIGNATURE <i>William A. Pillsbury</i>		22b. DATE SIGNED 6-1-67			
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury		22d. ADDRESS 2060 York Rd., Timonium, Md.			
23a. BURIAL, CREMATION, BONE (Specify)		23b. DATE THEREOF June 3, 67	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial	23d. LOCATION (City or Town) (County) (State) Parkville, Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.			ADDRESS	25a. REG'D BY REGISTRAR JUN 5 1967	25b. REGISTRAR'S SIGNATURE <i>Glenda J. Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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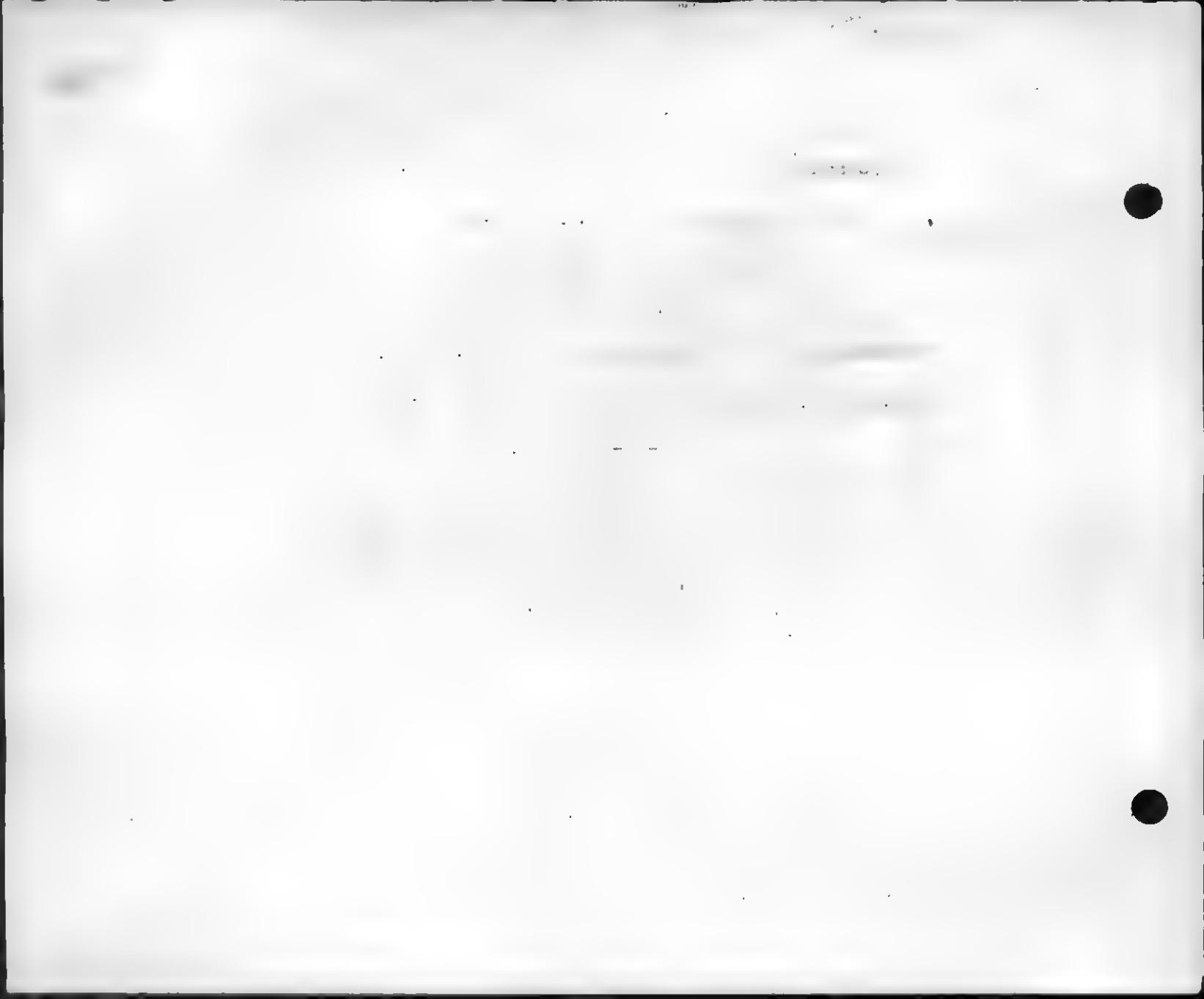
1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 9630 Alda Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Henry	First	Middle C.	Last Schoeberlein	4. DATE OF DEATH May 1 1967	Month May	Day 1	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> X NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/31/1904	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 0	Hours 0
10a. USLAI OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & S		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Schoberlein		14. MOTHER'S MAIDEN NAME Fredricka Boehner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-5428		17. INFORMANT Family records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraventricular hemorrhage, left hemisphere of brain Cond.ons, if any, which gave rise to immediate cause (a). stating the underlying cause lost. Atherosclerotic heart disease with hypertension.		INTERVA. BETWEEN ONSET AND DEATH					
DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. May 1, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that no (this hospital) attended the deceased from May 1, 1967 , to May 1, 1967 , that no (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 05p M, from causes and on the date stated above.							
22a. SIGNATURE Juana S. Cockburn		22b. DATE SIGNED May 2, 1967					
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/5/67		23c. NAME OF CEMETERY OR CREMATORIUM Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR C.F. EVANS & SON		ADDRESS 8802 Harford road		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
20 M 1/68		DATE MAY 3 1967					



Hospital or Attending Physician
Page 4 may be retained by the hospital or attending physician.

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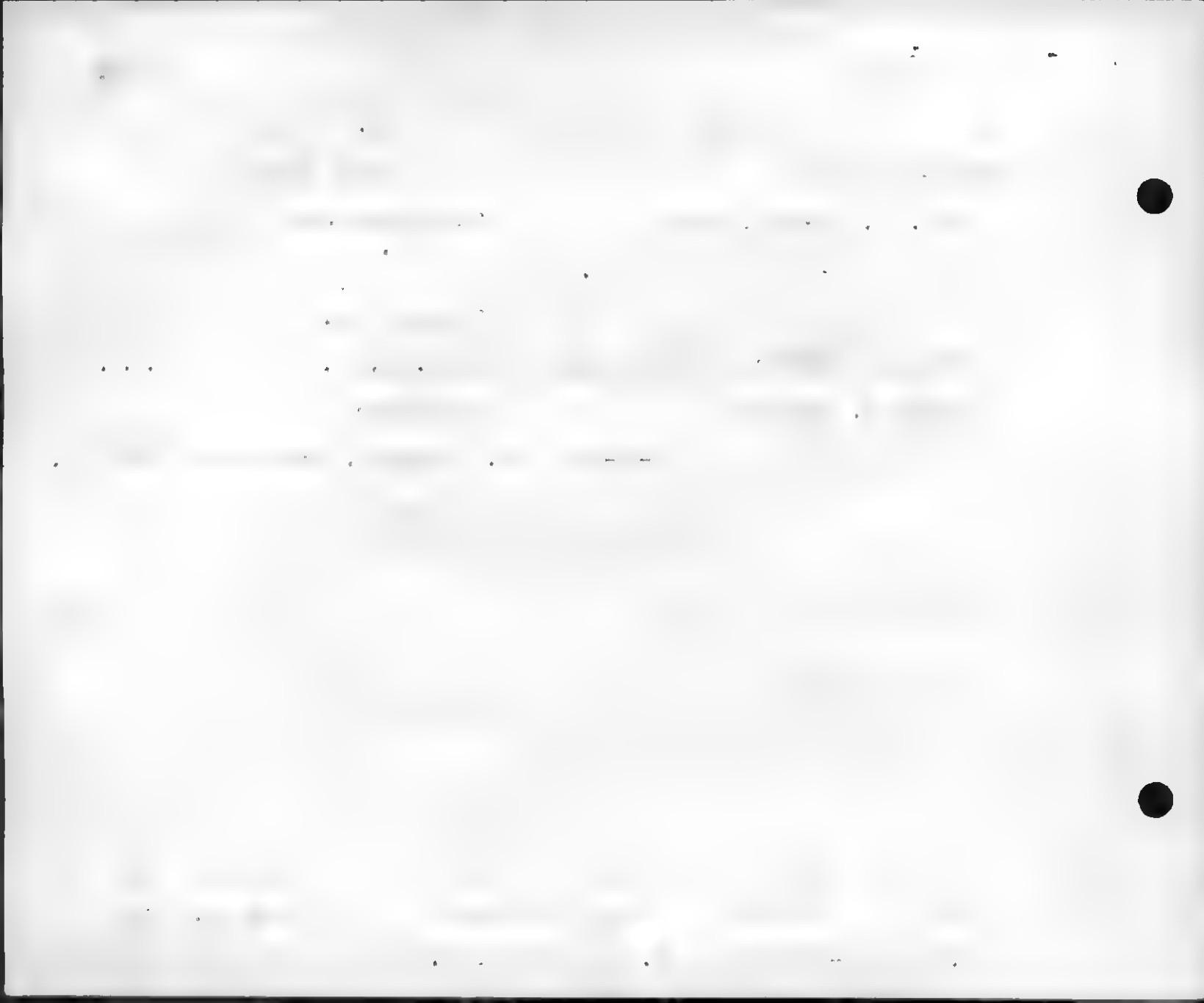
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
Item 2 Film G388 5/11/67 kk CERTIFICATE OF DEATH															
1. PLACE OF DEATH BALTIMORE COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY		G B M C county Baltimore		a. STATE Florida		b. COUNTY Baltimore		16205							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Nutherville, MD 16104/3							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS Princess Isenna Hotel											
Greater Baltimore Medical Center				Gallerie Manor Nursing Home											
3. NAME OF DECEASED First Mabel Middle Last				4. DATE OF DEATH				5. IS RESIDENCE ON A FARM?							
Mabel C Schuchart				MAY 7 1967				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR					
Female		Cav		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		2/18/85		82 yrs.		Months Days Hours Min.					
11a. USUAL OCCUPATION (Give kind of work done during				10b. KIND OF BUSINESS OR TRY				11. BIRTHPLACE (County & State, or foreign country)							
Housewife								Baltimore, Maryland							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?							
Joseph Linthicum				Smith				U.S.A.							
15. WAS DECLARED DEAD IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT							
No None				143-05-4288				Patients Chart							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				Address											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				INTERVAL BETWEEN ONSET AND DEATH											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				5 Yrs											
(b) cause (a), stating the underlying cause last.				Congestive heart failure											
(c)				Respiratory difficulty secondary to											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				Abdominal distension by fluid due to paralytic ileus											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19															
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on MAY 3 1967, and that death occurred at 3 PM, from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
22a. SIGNATURE				Seock, E. Chang											
22c. PHYSICIAN'S NAME (Type)				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> May 7, 67											
22d. ADDRESS				G B M C											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)				(State)			
Burial				5/10/67		David Ridge Cemetery		Pikesville, Md.							
24. FUNERAL DIRECTOR				ADDRESS								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. J. Tichner & Sons				Baltimore, Md.								DATE MAY 8 1967		Charles Judge	
20M 1/65															



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

26407		15506					
1. PLACE OF DEATH a. COUNTY <i>BALTIMORE COUNTY GEN HOSP</i> <small>MARYLAND</small> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <small>Rural-Randallstown</small>		2. USUAL RESIDENCE (Where deceased lived, if inst tut an Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown 21133</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp.tol, give street address) <i>Balt. Co. General Hospital</i>		d. STREET ADDRESS <i>3705 Cassen Road</i>					
3. NAME OF DECEASED (Type or print) <i>CHARLES L. SCHWARTZ</i>		First <i>CHARLES</i> M	Middle <i>L.</i> Jr.	Last <i>SCHWARTZ</i> 3/4/1890	4. DATE OF DEATH Month <i>5</i> Day <i>10</i> Year <i>1967</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <small>WIDOWED</small> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>77 yrs.</i>		9. AGE (In years last birthday) <small>YRS.</small>	10. IF UNDER 1 YEAR <small>MONTHS DAYS HOURS MIN</small>	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stationary Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cold Storage</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Balt. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles L. Schwartz</i>		14. MOTHER'S Maiden Name <i>Lydia Raver</i>		Address <i>Randallstown 3705 Cassen Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		<small>PART I. DEATH WAS CAUSED BY</small> <small>IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i></small> <small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>CORONARY THROMBOSIS</i></small> <small>DUE TO</small> <small>(c)</small>				<small>INTERVAL BETWEEN ONSET AND DEATH</small>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? <small>YES <input type="checkbox"/> NO <input type="checkbox"/></small>	
20c. TIME OF INJURY Month, Day, Year <small>Hour o.m. p.m.</small> <i>19</i>		20d. INJURY OCCURRED <small>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></small>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/10/67</i> to <i>5/10/67</i> that (I) (we) last saw the deceased alive on <i>5/10/67</i>, and that death occurred at <i>7 P.M.</i> from causes and on the date stated above. 						22b. DATE SIGNED <i>5/10/67</i>	
22a. SIGNATURE <i>Mario G. Tolentino</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>MARIANO A. TOLENTINO</i>		22d. ADDRESS <i>301 ST. PAUL ST. BALTIMORE MD 21202</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/13/67</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Druid Ridge Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Md. 21208</i>	
24. FUNERAL DIRECTOR <i>Loring Byers-5728 Liberty Rd. Randallstown, Md.</i>		ADDRESS 		25a. REC'D BY REGISTRAR <i>MAY 15 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
<small>VR A15 (4) 20 M 1/68</small>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

26408

CERTIFICATE OF DEATH

JCBY

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, 21093		d. STREET ADDRESS 1101 Hemsley Court		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1101 Hemsley Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Marie	Middle C.	Last Scotney	4. DATE DEATH May 2 1967	Month May	Day 2	Year 1967
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/1916	9. AGE (in years last birthday) 50 yrs.	10. FUNDER 1 YEAR Months 50	11. FUNDER 24 HRS Days Hours Min. 0 0 0 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Bendix Corp.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William A. Kammeir		14. MOTHER'S MAIDEN NAME Mary V. Collins						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-1501		17. INFORMANT Herbert M. Scotney		Address (Same)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>10/18</i>		Calcium of Breast				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO						
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 1967 to May 2 1967 , that (I) (we) last saw the deceased alive on May 2 1967 , and that death occurred at HPM , from the causes and on the date stated above.								
22a. SIGNATURE <i>Will H. Fusting</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-4-67				
22c. PHYSICIAN'S NAME (Type) Dr. William H. Fusting		22d. ADDRESS 4230 Loch Raven Blvd.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS New Cathedral H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		23d. LOCATION (City, town or county) (State) Baltimore Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR DATE 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36409

CERTIFICATE OF DEATH

15208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.****TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>417 LOGTS LANE</u>		e. STREET ADDRESS <u>417 LOGTS LANE</u>	
3. NAME OF DECEASED (Type or print) <u>EMANUEL</u>		First <u>E.</u>	Middle <u>S.</u> SHAPIRO
4. DATE OF DEATH Month <u>MAY</u>	Day <u>19</u>	Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>SEPT. 21, 1902</u>	9. AGE (In years lost birthday) <u>64 yrs</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u>	
13. FATHER'S NAME <u>JOSEPH SHAPIRO</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>167-28-5214</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN DEATH</u>			
19. WAS A TUMPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.M. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>APR. 13, 1956</u> , to <u>MAY 19, 1962</u> , that (I) (we) last saw the deceased alive on <u>MAY 12, 1962</u> , and that death occurred at <u>6:45 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Miceli</u>		22b. DATE SIGNED <u>5/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI, M.D.</u>		22d. ADDRESS <u>108 S. TAYLOR AVE ESSEX, MD 21221</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/22/67</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Fowler Park</u>
23d. LOCATION (City or Town) <u>Balto, Md.</u>		(County) (State)	
24. FUNERAL DIRECTOR <u>J. H. Connally Son 300 maces</u>		ADDRESS <u> </u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>
		DATE <u>MAY 23, 1967</u>	25b. REGISTRAR'S SIGNATURE



1 8
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36470 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16399

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institut or Residence before admission) a. STATE Maryland Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) On Way to St. Joseph Hospital			e. STREET ADDRESS 1640 Thetford Road		
3 NAME OF DECEASED (Type or print) James Coleman			First d	Middle Shipley, Sr.	4 DATE OF DEATH 5 23 1967
S SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12/23/21		9. AGE (In years old birthday) 45 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radar Engineer			10b. KIND OF BUSINESS OR INDUSTRY Bendix Radio Corp.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME John William Shipley, Sr.			14. MOTHER'S MAIDEN NAME Margaret Francis Gilbert		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give major dates of service) Yes W.W.I			16. SOCIAL SECURITY NO. 220-07-5652	17. INFORMANT Family: records	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Burns Sons Towson		
23a. BURIAL, CREMATION, REMOVAL, (Specify) Cremation	23b. DATE THEREOF May 26, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County) (State)	
24. FUNERAL DIRECTOR John Burns Sons	ADDRESS Towson	25a. REC'D BY REGISTRAR Judge	25b. REGISTRAR'S SIGNATURE John Burns Sons	DATE May 26 1967	



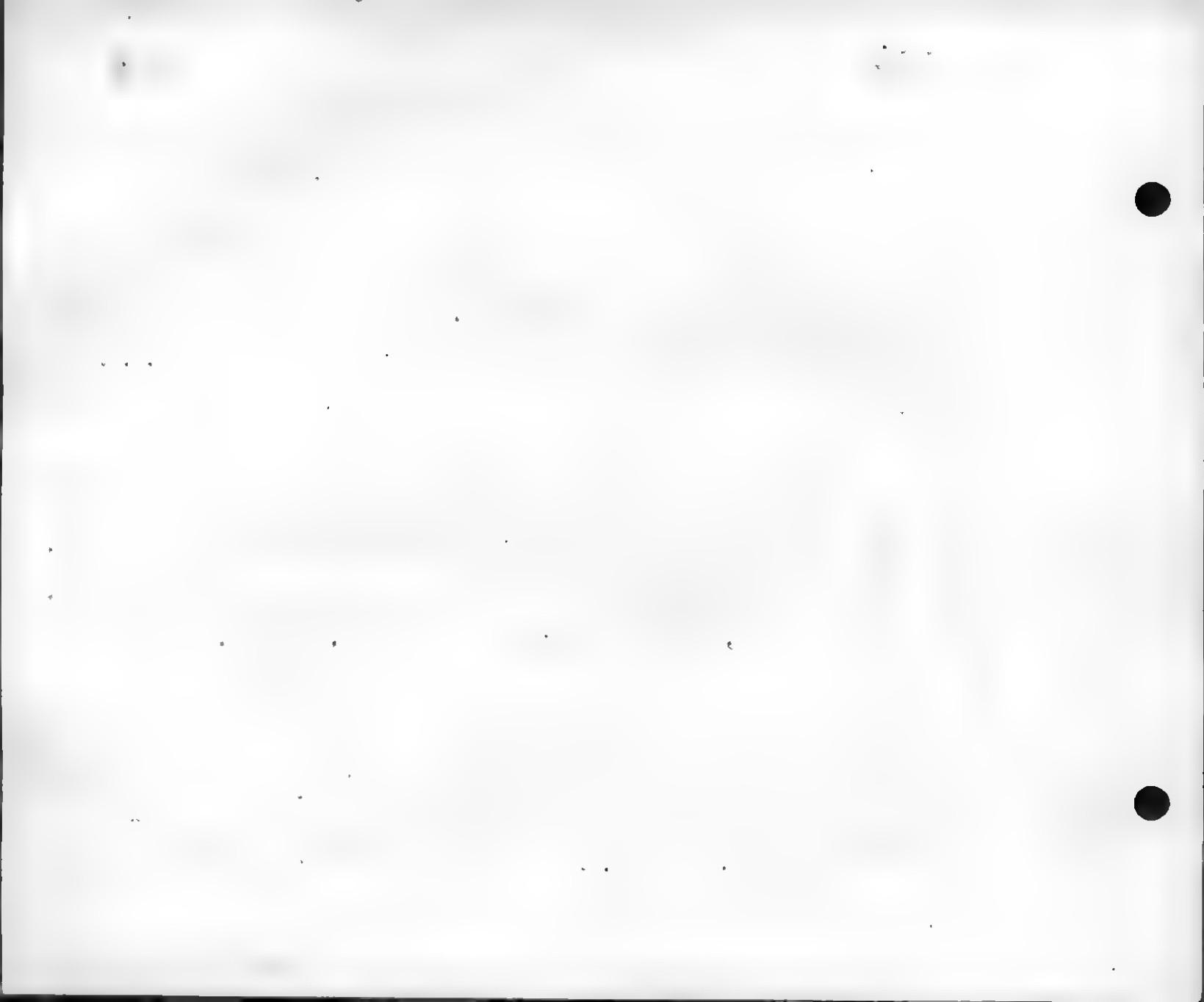
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

M 06411		SC 100									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if instit. an residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 2yr9mth 21days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant, Maryland							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 6707 Eade Street				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pearl		First B Middle Shumate		4. DATE OF DEATH Month May Day 8 Year 1967							
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1900		9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS Hours 0 Min 0		
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Isaac Brown				14. MOTHER'S MAIDEN NAME Rebecca Caffee							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 579-03-0349D			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction								INTERVAL BETWEEN ONSET AND DEATH acute			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause last				(b) Arteriosclerotic cardiovascular Heart Dis 3 yrs.							
				(c) Arteriosclerosis, Generalized, senile 3 yrs.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Decubitus Ulcers, Sacrum and right heel, Inf. with P. Aeruginosa											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS A POSTMORTEM EXAMINATION PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 17, 1961 to May 8, 1967 , that (I) (we) last saw the deceased alive on May 8, 1967 , and that death occurred at 7:15 P.M. from causes and on the date stated above.								22b. DATE SIGNED 5-9-67			
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>				ATTENDING MED STAFF M.O. PHYS. <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.				22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-17-1967		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Hall		23d. LOCATION (City or Town) (County) (State) Towson					
24. FUNERAL DIRECTOR Anthony J. Young, M.D.		ADDRESS 131-1166 St. S.E. D.C.		25a. REC'D BY REGISTRAR DATE MAY 12 1967		25b. REGISTRAR'S SIGNATURE Charles J. ...					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

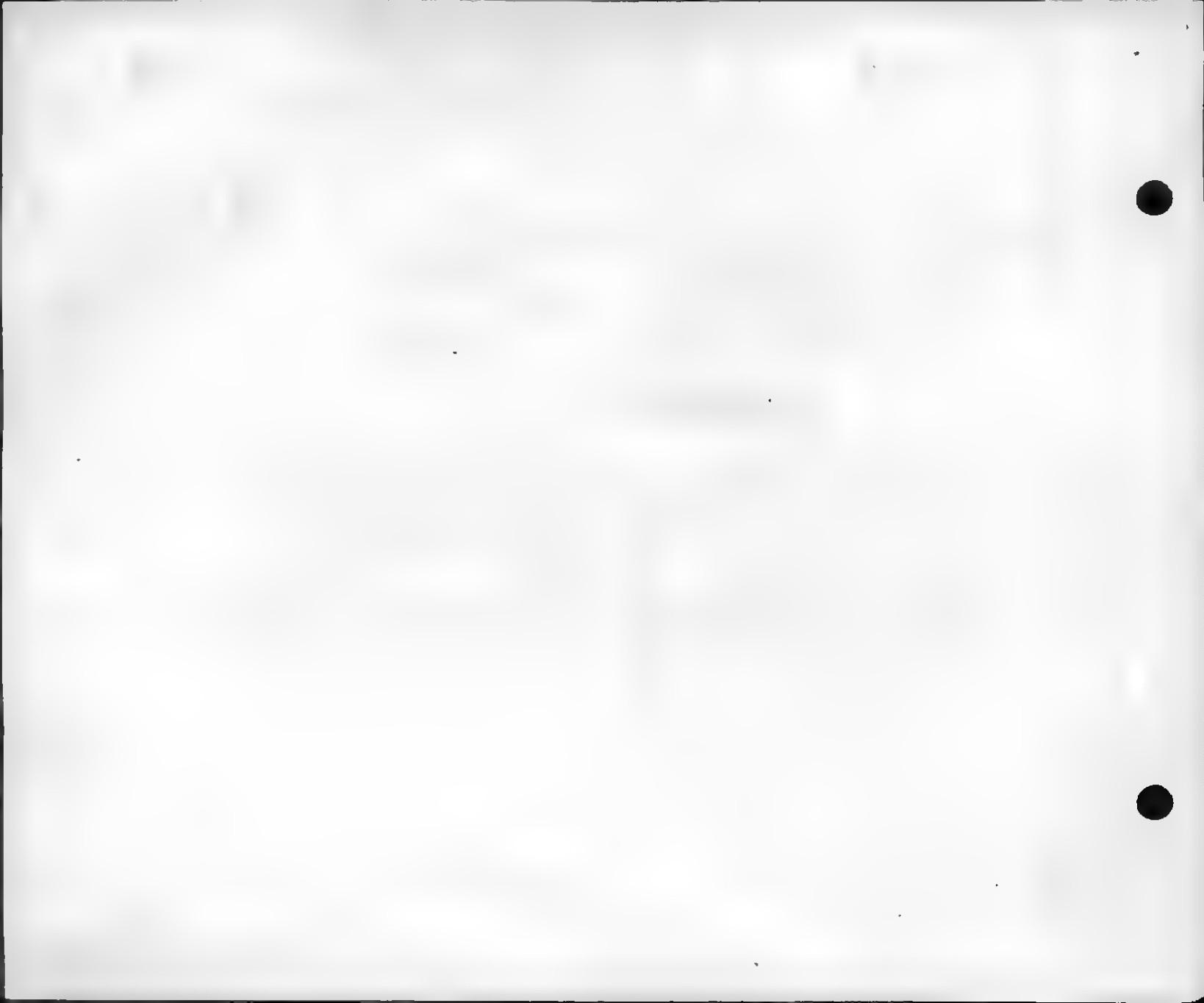
36412

CERTIFICATE OF DEATH

36412

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE M.D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSBURG		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHERINE		First K , Middle A , Last SIEBEL	4. DATE OF DEATH Month 5 - Day 1 - Year 1967
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 9-14-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
10c. FATHER'S NAME LEVI KIRSON		11. BIRTHPLACE (County & State, or foreign country) LATVIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. MOTHER'S MAIDEN NAME BESSIE Bracken	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NO	
17. INFORMANT MORTON H. PERRY, ESQ., EQUITABLE BLDG.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) GENERALIZED ARTEROSCLEROSIS DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO lost (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2008 days	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) CA OF PANCREAS WITH METASTASIS; DEHYDRATION	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/23/67 , 19 19 , to 5/1/67 , 19 19 , that (I) (we) last saw the deceased alive on 5/1/67 , 19 19 , and that death occurred at 11:20 PM , from causes and on the date stated above.		22b. DATE SIGNED 5-1-67	
22c. PHYSICIAN'S NAME (Type) NATHAN NEEDLE		22d. ADDRESS PARK HEIGHTS AVENUE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/3/67	23c. NAME OF CEMETERY OR CREMATORIAL BNAI ISRAEL
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REIST., RD.	25a. REC'D BY REGISTRAR MAY 5 1967
			25b. REGISTRAR'S SIGNATURE J Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

36413

CERTIFICATE OF DEATH

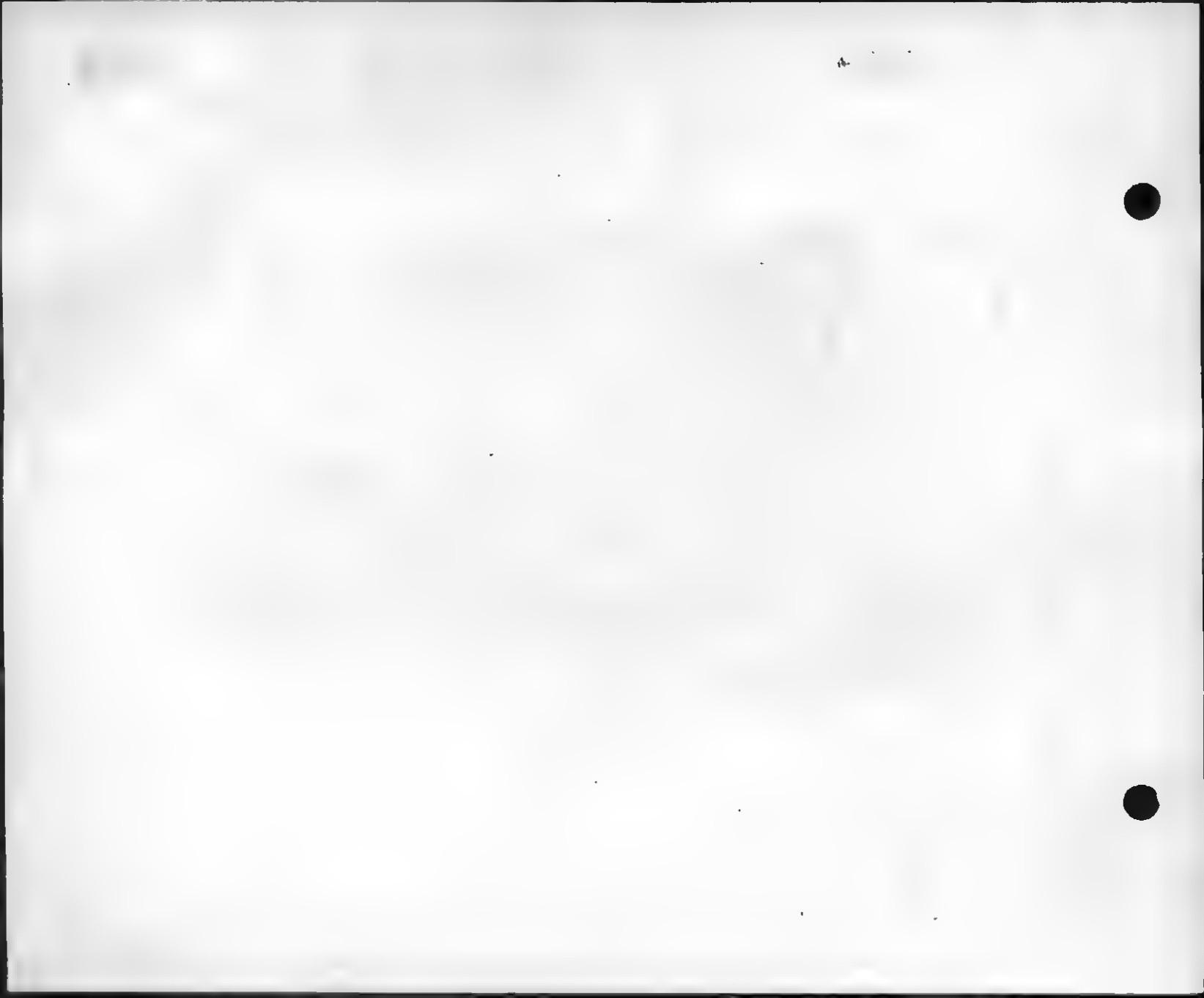
DE402

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		Item 8 Part 5 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN TB <i>24 Days</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <i>3533 Reisterstown Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ida</i>		First	Middle	Last	4. DATE OF DEATH <i>May 22 1967</i>	Month	Day	Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-21-1895</i>	9. AGE (In years last birthday) <i>71 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Europe</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Abram</i>		14. MOTHER'S MAIDEN NAME <i>Rochard</i>		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>124-05-4834</i>		17. INFORMANT <i>Seymour Silberstein</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of colon</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 mo.</i>
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>None</i>		OUE TO (b) <i>None</i>		OUE TO (c) <i>None</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Sept 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Randallstown</i>		(County) <i>Md.</i>	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 16</i> , 1967, to <i>5-22-1967</i> , that (I) (we) last saw the deceased alive on <i>5-22-1967</i> , and that death occurred at <i>39</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Seymour Sauber</i>		22b. DATE SIGNED <i>5-23-67</i>							
22c. PHYSICIAN'S NAME (Type) <i>IRWIN SAUBER</i>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		M.D. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/24/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Beth El</i>		23d. LOCATION (City, town or county) <i>Randallstown</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Syphon S. Lewis & Son, Inc Garrison, Md</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>MAY 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

JE 193

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN MD <u>Unknown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>3016 Christopher Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Rose</u>	Middle <u>Estelle</u>	Last <u>Silverthorne</u>	4. DATE OF DEATH Month <u>5</u>	Month <u>24</u>	Doy <u>1967</u>	Year
S. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>10/10/1876</u>	9. AGE (In years last birthday) <u>90 yrs</u>	IF UNDER 1 YEAR Months <u></u>	IF UNDER 24 HRS Days <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Concord, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Churn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>223-70-6995</u>		17. INFORMANT <u>Virginia Stevens</u>		Address <u>3016 Christopher Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>lost</u>		DUE TO <u>C.V.A.</u>				INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO							
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> , 19 <u>67</u> , to <u>5-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-24</u> 19 <u>67</u> , and that death occurred at <u>2:45 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Ram E. Chhillar</u>		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Ram E. CHHILLAR</u>		22d. ADDRESS <u>GTR. BALTIMORE MED. CENTER BALTIMORE, MD.</u>		22e. DATE SIGNED <u>5/24/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-27-1967</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>NELSON CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>ROCOMORE CITY, BPD, MD.</u>	
24. FUNERAL DIRECTOR <u>Rodney N. Watson</u>		ADDRESS <u>ROCOMORE CITY, BPD, MD.</u>		25a. MADE BY REGISTRAR <u>MAY 29 1967</u>		25b. CERTIFIED STATUS <u>Judge</u>	
VR A15 (4) 25M 1/67							



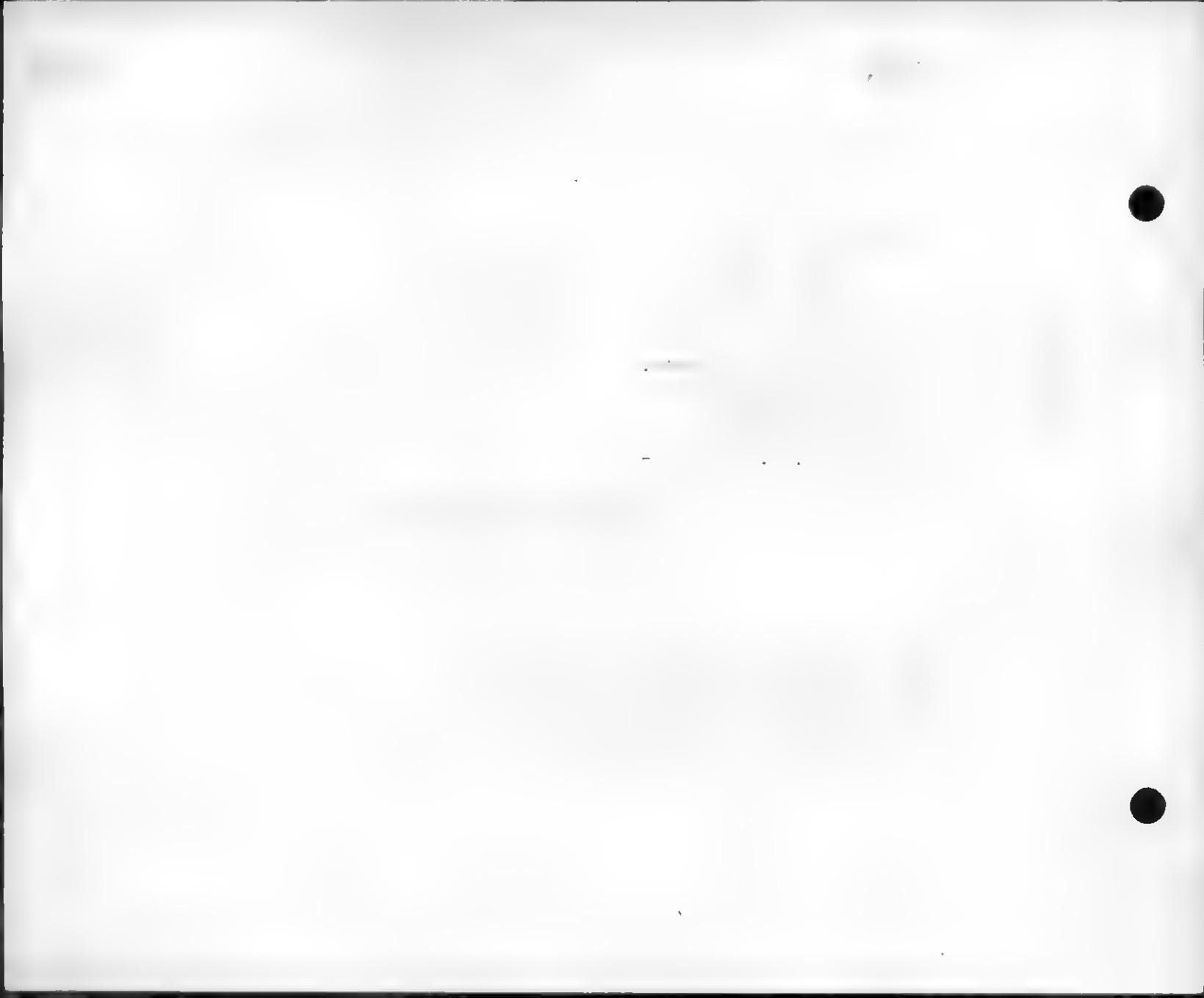
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

JF 104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

36415		CERTIFICATE OF DEATH								
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN HB Hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium, 21093 d. STREET ADDRESS 16 Northwood Dr.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Andrew		First	Middle	Lost	4. DATE OF DEATH	Month	Doy	Year		
S SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH 12-4-1907	9 AGE (in years last birthday) 59 yrs	F UNDER 1 YEAR Months 3	I IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher			10b. KIND OF BUSINESS OR INDUSTRY Owner-			11 BIRTHPLACE (County & State, or foreign country) New Jersey			12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Skerchek				14. MOTHER'S MAIDEN NAME Pearl Herila						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. W. W. TWO			17. INFORMANT Natalie Skerchek, Same as # 2			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis. DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO stating the underlying cause lost. (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute pulmonary edema									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HDW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Woodbridge	(County) New Jersey	(State) U.S.A.
21. I certify that (A) (this hospital) attended the deceased from May 30, 1967 to May 30, 1967 , that (A) (we) last saw the deceased alive on May 30, 1967 , and that death occurred at 11:45M , from causes and on the date stated above.									22b. DATE SIGNED May 31, 1967	
22a. SIGNATURE 			M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.			22d. ADDRESS 7620 York Rd., Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 3, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Clover Leaf Park			23d. LOCATION (City or Town) (County) (State) Woodbridge, New Jersey			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road			ADDRESS Towson, Maryland 21204			25a. REC'D BY REGISTRAR JUN 5 1967		25b. REGISTRAR'S SIGNATURE 		
VR A15 (4) 25M 1/67										



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

06416

CERTIFICATE OF DEATH

36105

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN TB 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEMERE BALTIMORE COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 3229 LYNCH ROAD		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle NMI	Surname SMITH	4. DATE OF DEATH MAY 10 1967	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/96	9. AGE (In years lost birthday) 71 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL CO.		11. BIRTHPLACE (Country & State or foreign country) Maryland EDGEMERE BALTO. COUNTY	
13. FATHER'S NAME FRANK STACHOWSKI			14. MOTHER'S MAIDEN NAME CATHERINE TOMCZEWSKI		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO 213 09 15 41		17. INFORMANT Address CLINICAL RECORDS VAH FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) CARCINOMA OF THE LUNG, RIGHT, WITH METASTASIS DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 5 DAYS					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/6/1967 to 5/10 1967 , that (I) (we) last saw the deceased alive on 5/10 1967 , and that death occurred at p. M. from causes and on the date stated above.					
22a. SIGNATURE <i>Carmelita A. Cendana</i>		22b. DATE SIGNED 5-10-67			
22c. PHYSICIAN'S NAME (Type) CARMELITA A. CENDANA, M.D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		23b. DATE THEREOF 5/15/67		23c. NAME OF CEMETERY OR CREMATORIAL HOLY ROSARY CEMETERY	
24. FUNERAL DIRECTOR John J. Duda		ADDRESS Duda Funeral Home 7922 Wise Ave.		25a. REC'D BY REGISTRAR MAY 15 1967	
VR A15 (B) 25M 1/67				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
BALTIMORE 22, Md.					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06417

CERTIFICATE OF DEATH

JS406

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	c LENGTH OF STAY IN lb	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Paradise Nursing Home		d STREET ADDRESS 6205 Marietta Ave.	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) LILLIAN	First E.	Middle SMITH	4. DATE OF DEATH Month 5 Day 16 Year 1967		
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/6/83	9 AGE (In years last birthday) 84 yrs	10 IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Nelson		14. MOTHER'S MAIDEN NAME Ida Lukun			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	17. INFORMANT	Address Nelson E. Smith-6205 Marietta Ave.	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <i>Generalized Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Chronic Bronch Syndrome</i> (c) DUE TO <i>Decubitus Ulcer</i>				INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 3 yrs. 3 months.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3/13/67	20f. (City or town) Baltimore	(County) (State) Md.
21. I certify that (I) (this hospital) attended the deceased from <u>3/13/67</u> , to <u>3/16/67</u> , that (I) (we) last saw the deceased alive on <u>3/15/67</u> , and that death occurred at <u>Baltimore</u> M, from causes and on the date stated above.					
22a. SIGNATURE <i>N.E. McClellan</i>		MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS		22b. DATE SIGNED 5/17/67	
22c. PHYSICIAN'S NAME (Type) N.E. McClellan M.D.		22d. ADDRESS 1303 Frederick Rd. (2nd flr)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Pk	23d. LOCATION (City or Town) Baltimore, Maryland	(County) (State)
24. FUNERAL DIRECTOR Robert C. Altenburg - Funeral Home, Inc.		ADDRESS 6009 Harford Rd.	25a. REC'D BY REGISTRAR DATE MAY 18 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove conon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

06418

06407

1. PLACE OF DEATH a. COUNTY BALTO			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b CATONSVILLE		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 116 Woodlawn Ave			d. STREET ADDRESS 116 Woodlawn Ave					
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RUTH J. SMULLEN			First	Middle	Last			
4. DATE OF DEATH 5/27 1967	Month	Day	Year					
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH 3/25/08	9. AGE (In years last birthday) 59 yrs.	IF UNDER Months Days	10. CAR Hours	11. IF UNDER 24 HRS Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) NEW YORK	12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME HARRY BOLTON			14. MOTHER'S MAIDEN NAME FLORENCE ML. MILLLEN			Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ied myself f. house of Metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Ca of Breast DUE TO last (c)			
					INTERVAL BETWEEN ONSET AND DEATH Months.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 12/27/1966 to 5/28/1967 , that (I) (we) last saw the deceased alive on 5/23/1967 , and that death occurred at 2:30 P.M. from causes and on the date stated above.								
22a. SIGNATURE Dean Admire MD			M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 5/29/1967	
22c. PHYSICIAN'S NAME (Type) Adnan Sonmez			22d. ADDRESS 1011 Frederick Road Balt. Md 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 5/30/67	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		23d. LOCATION (City or Town) BALTO Md.			
24. FUNERAL DIRECTOR E.S. MACNABIR		ADDRESS 301 FREDERICK RD 21228	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			
			DATE JUN 1 1967					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

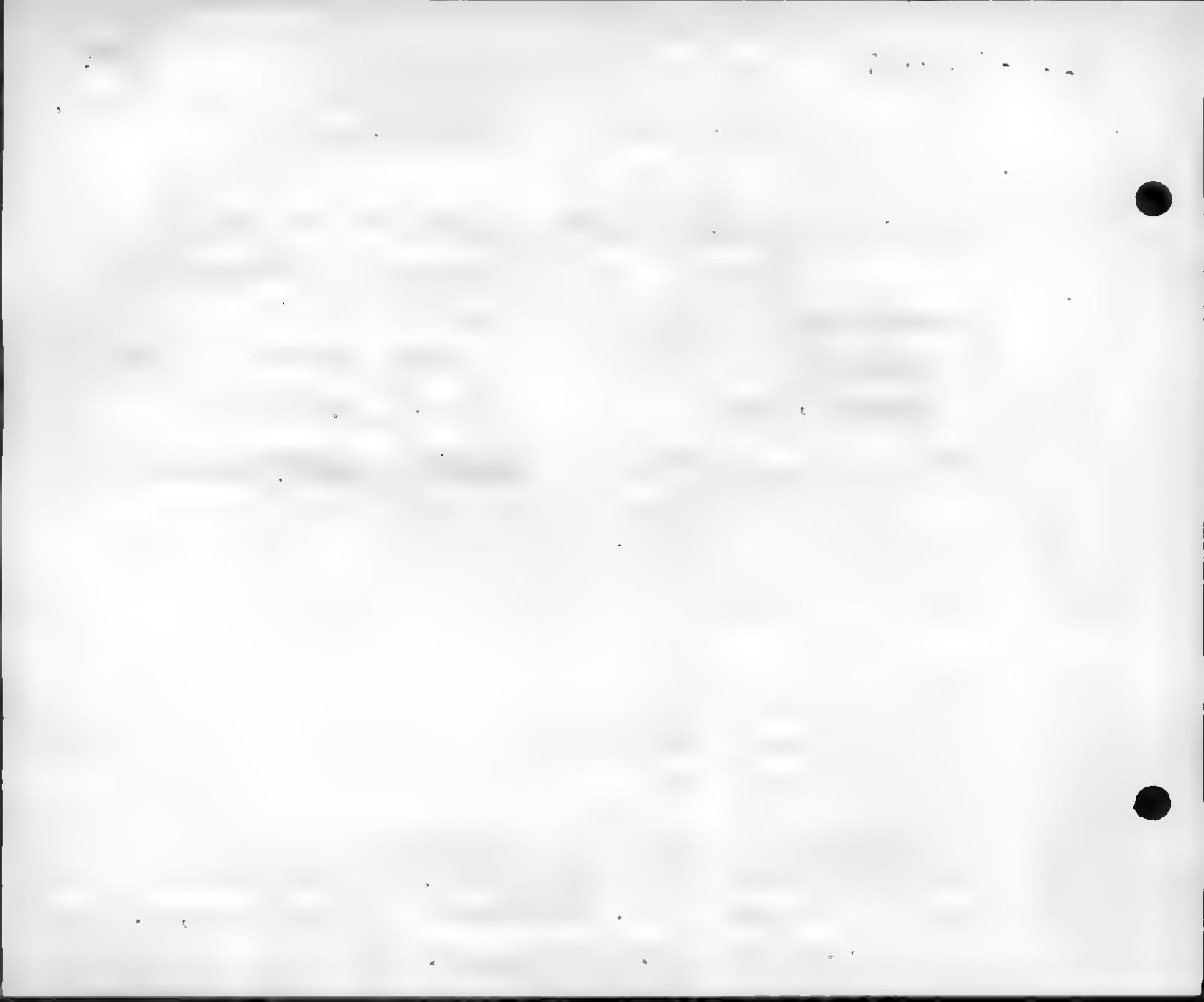
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06413 06408

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore County General Hosp.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Baltimore</i> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore County General Hosp.</i>		d. STREET ADDRESS <i>3409 Turb Rd.</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>Katherine</i>	Middle <i>Snyder</i>	4. DATE OF DEATH <i>May 11, 1967</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Retired</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>				
9. ON USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10. KIND OF BUSINESS OR INDUSTRY <i>None</i>					
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>					
13. FATHER'S NAME <i>Leibel, Louis</i>		14. MOTHER'S MAIDEN NAME <i>Sondi Melvin</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>					
17. INFORMANT <i>Carol Snyder</i>		18. INTERVAL BETWEEN ONSET AND DEATH <i>None</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Failure of pancreas</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause last (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>None</i>	(County) <i>None</i>	(State) <i>None</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>5-11-1967</i> to <i>5-11-1967</i> , that (I) (we) last saw the deceased alive on <i>5-11-1967</i> , and that death occurred at <i>94th St</i> M, from causes and on the date stated above				22b. DATE SIGNED <i>5-11-67</i>			
22a. SIGNATURE <i>W.L.</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22d. ADDRESS <i>B.C.G. Hospital</i>				
22c. PHYSICIAN'S NAME (Type) <i>Dr. Lai</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/13/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Olive Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Randallstown, Md. 21133</i>
24. FUNERAL DIRECTOR <i>Loring Byers-5728 Liberty Rd. Randallstown, Md.</i>		25a. REC'D BY REGISTRAR <i>DAT</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		MAY 15 1967	
VR A15 (4) 20 M 1/66							



FOR STATE
HEALTH DEP

The State Department of
Agriculture
in 72 hours after death

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If "any" delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

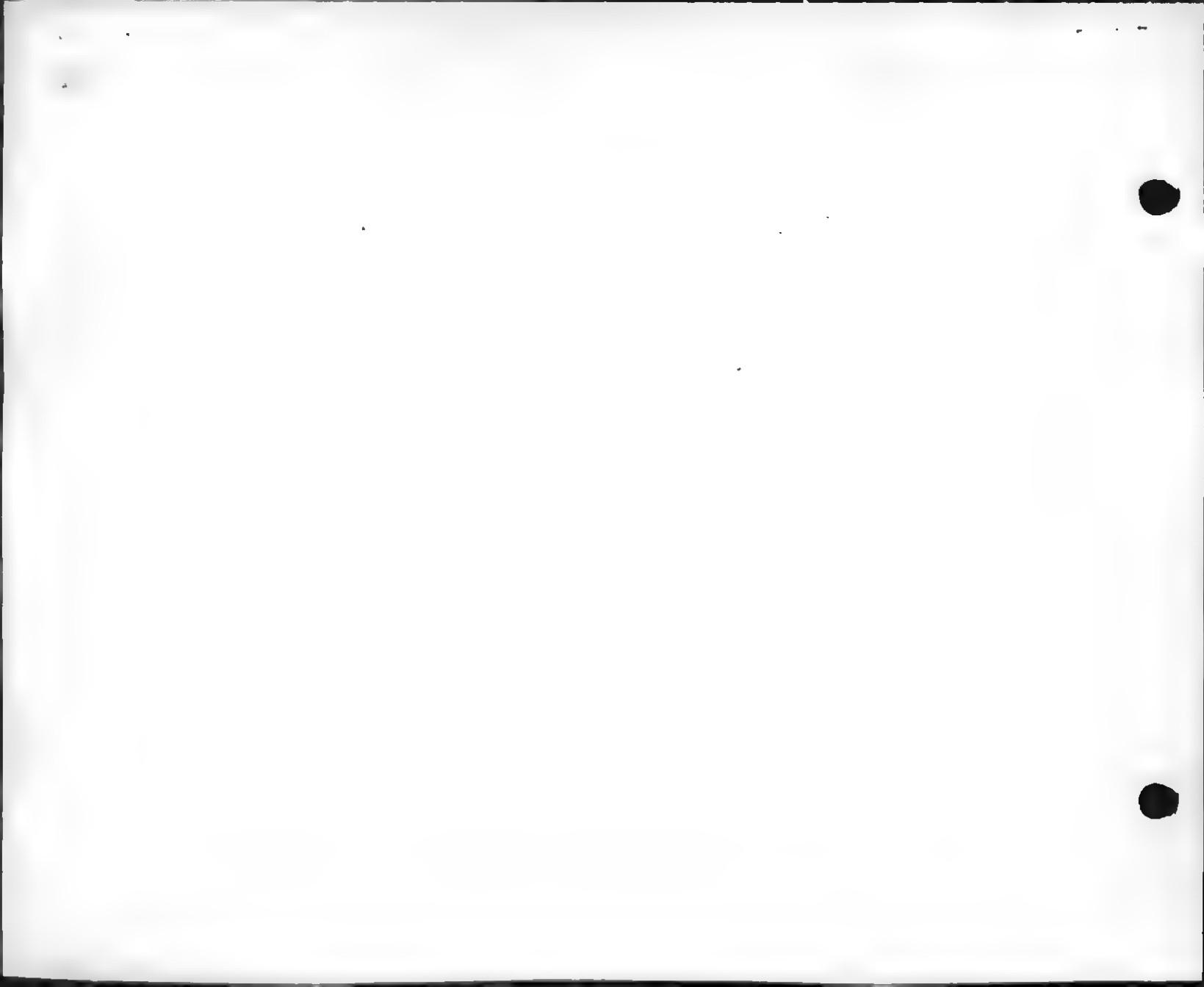
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 shau

10 Fl
Head

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH a. COUNTY Baltimore			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN b 12	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		b COUNTY BALTIMORE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1013 ST. ARTHUR RD			d. STREET ADDRESS 1013 ST. ARTHUR RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First THOMAS	Middle WALTER	Last SOMMER	4. DATE OF DEATH MAY 27 1967	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH OCT. 23, 1881	9. AGE (In years, last birthday) 85 yrs	F UNDER 1 YEAR Months Days Hours Min
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONCRETE FINISHER			10b. K IND OF BUSINESS OR INDUSTRY CONCRETE IND.	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME John Bartine J. BATINE			14. MOTHER'S MAIDEN NAME MAGGIE A. HERBST		Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOC A. SECURITY NO 216-18-0257	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office building, etc.)	20f. (City or town) BALTIMORE, MD.	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William A. Parsons	MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) William A. Parsons			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22. DATE SIGNED May 31, 1967					
23a. BURIAL CREMATION, REMOVAL (Special) BURIAL	23b. DATE THEREOF May 31, 1967	23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE CEMETERY	23d. LOCATION (City or Town) BALTIMORE, MD.	(County)	(State)
24. FUNERAL DIRECTOR John Burns Sons, Towson, Md.	ADDRESS Towson, Md.	25a. REC'D BY REGISTRAR WILLIAM J. CHARLES JONES	25b. REGISTRAR'S SIGNATURE Charles Jones		



Item 18 Film 389 6-14-67 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death
necessary, please execute the certificate writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

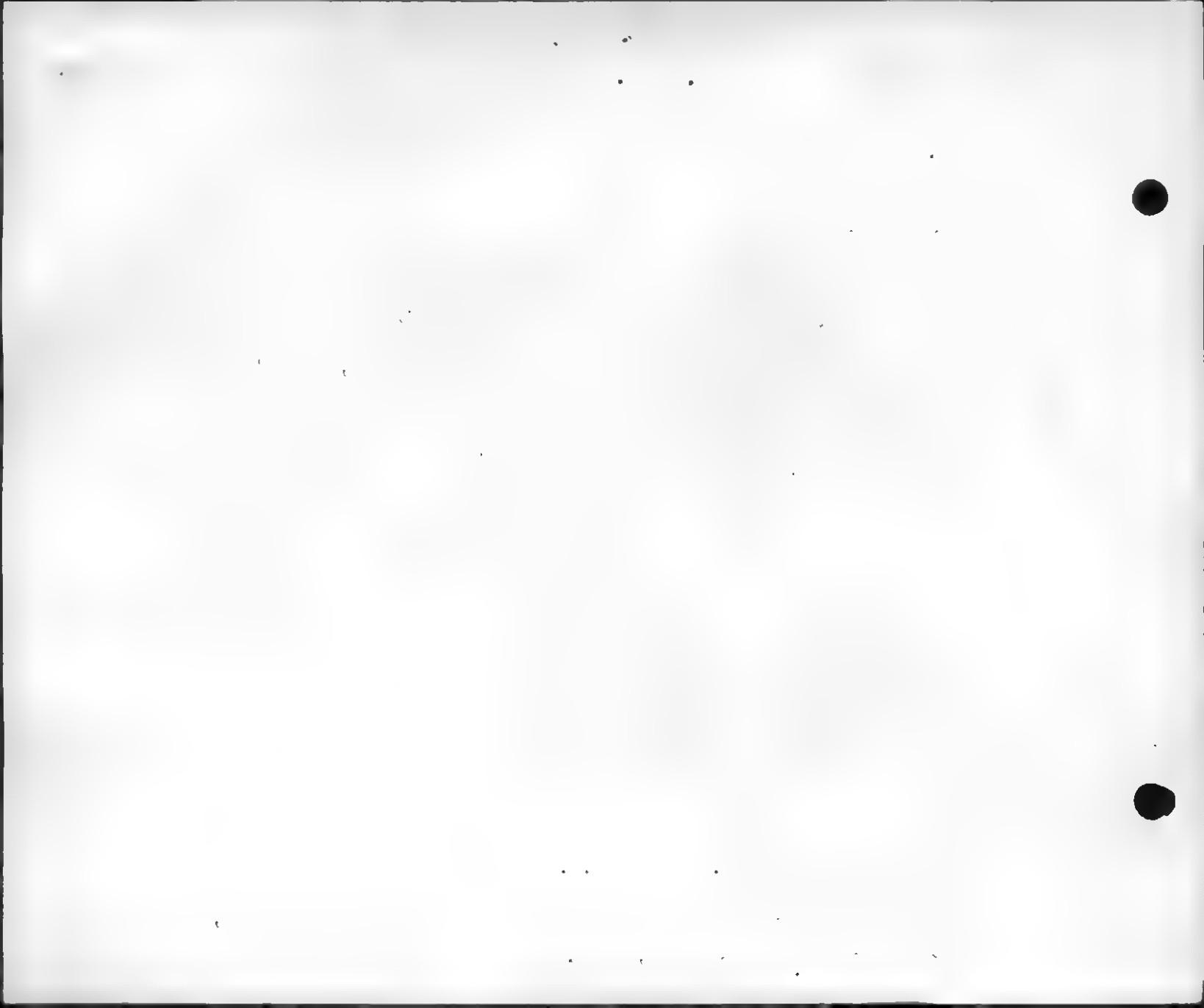
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death

96421

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

964210

1 PLACE OF DEATH a COUNTY Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) b STATE Maryland		b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Baltimore		d STREET ADDRESS 1419 Limit Avenue 21212	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) DARCY		First	Middle	4 DATE OF DEATH SPICKA	Month	Day	Year
S SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B DATE OF BIRTH May 16, 1967	9 AGE (In years last birthday) yrs 5	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS Days Hours Min
10c USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Richard Spicka		14 MOTHER'S MAIDEN NAME Janice Hall					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIA. SECUR. NO. None		17 INFORMANT Richard Spicka		Address Same	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 754! Conditions, if any, wh ch gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH							
Interstitial pneumonitis / + (SDIT) / Congestive heart failure Patent ductus arteriosus							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Interstitial pneumonitis							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5-24-67	
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-67		23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd, 21212		ADDRESS 5-209367		25a. REC'D BY REGISTRAR DATE MAY 25 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
26422		CERTIFICATE OF DEATH										
		Item #16 Film #30005-5/10/67										
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		J8011				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson		c. LENGTH OF STAY IN MD		a. STATE		Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Greater Baltimore Medical Center		1557 Cottage Lane		b. COUNTY		Baltimore				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days	Hours	Min.	
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	09-23-99	67	yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Housewife				Baltimore, Md.		U.S.A.						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME										
J Oscar Hulse		Dixon, Rena										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address						
no		unknown		Mrs. Doris Naumann		same address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolization												
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) left femoral vein thrombosis												
DUE TO (c) Carcinomatosis - endometrial carcinoma												
INTERVAL BETWEEN ONSET AND DEATH 15 mos.												
2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
19												
21. I certify that (I) (this hospital) attended the deceased from February 19, 1966, to May 4, 1967, that (we) last saw the deceased alive on May 4, 1967, and that death occurred at 3 PM, from the causes and on the date stated above.												
22a. SIGNATURE Reinhold O. Goehl, Jr.												
22b. DATE SIGNED May 4, 1967												
22c. PHYSICIAN'S NAME (Type)		R.O. GOEHL, JR., M.D.		22d. ADDRESS 6701 N. CHARLES ST., BALTO. MD 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/1967		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCATION (City, town or county) Baltimore, Md.		(State)				
24. FUNERAL DIRECTOR Wm. J. Lehman & Sons		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR Date MAY 8, 1967		25b. REGISTRAR'S SIGNATURE Charles Judge						
4												
VR A15 (4) 20M 1/65												



MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

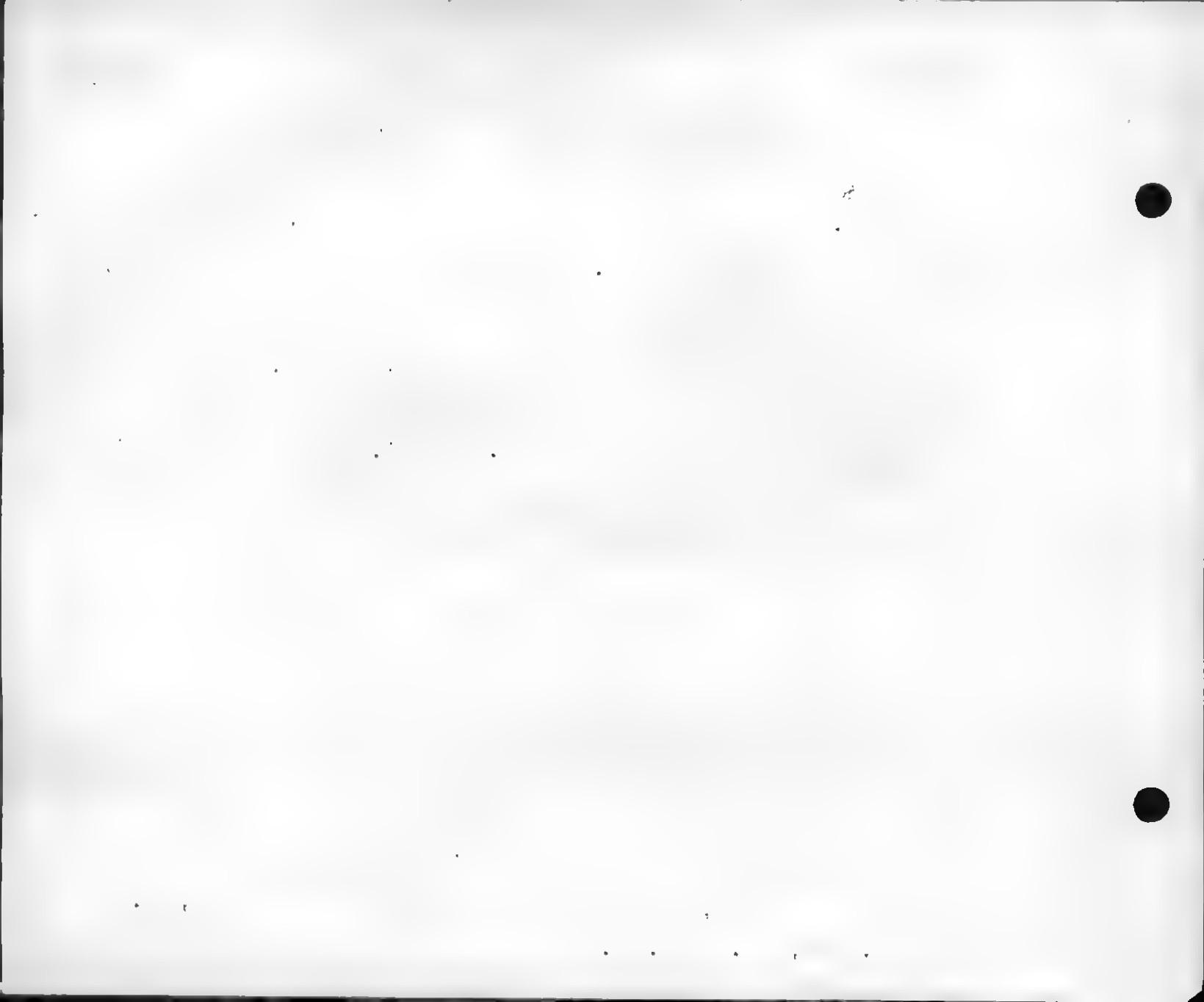
06423

CERTIFICATE OF DEATH

06112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 days after death.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN IB		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Caryn		First	Middle	Last	4. DATE OF DEATH Month	May	Doy	Year		
		A.	Stamm							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-28-67	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min. ✓	
					2	5				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Conrad Stamm										
15. WAS DECEASED EVER IN JS ARMED FORCES? (Yes, No, or Unknown) No					16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Edward C. Stamm	Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO 411X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) Bacteremia DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore	(County) Md.	(State) Md.			
21. I certify that 20 (this hospital) attended the deceased from April 5th, 1967 , to May 5th, 1967 , that 1 (we) last saw the deceased alive on May 5th, 1967 , and that death occurred at 5:10 AM , from causes and on the date stated above.										
22a. SIGNATURE <i>M. Chang</i>		22b. DATE SIGNED May 5, 1967								
22c. PHYSICIAN'S NAME (Type) Myung Y. Chang, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/67.	23c. NAME OF CEMETERY OR CREMATORIUM Gardens of Faith Cemetery		23d. LOCATION (City or Town) Baltimore		(County) Md.	(State) Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214		25a. RECD BY REGISTRAR DATE May 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06424

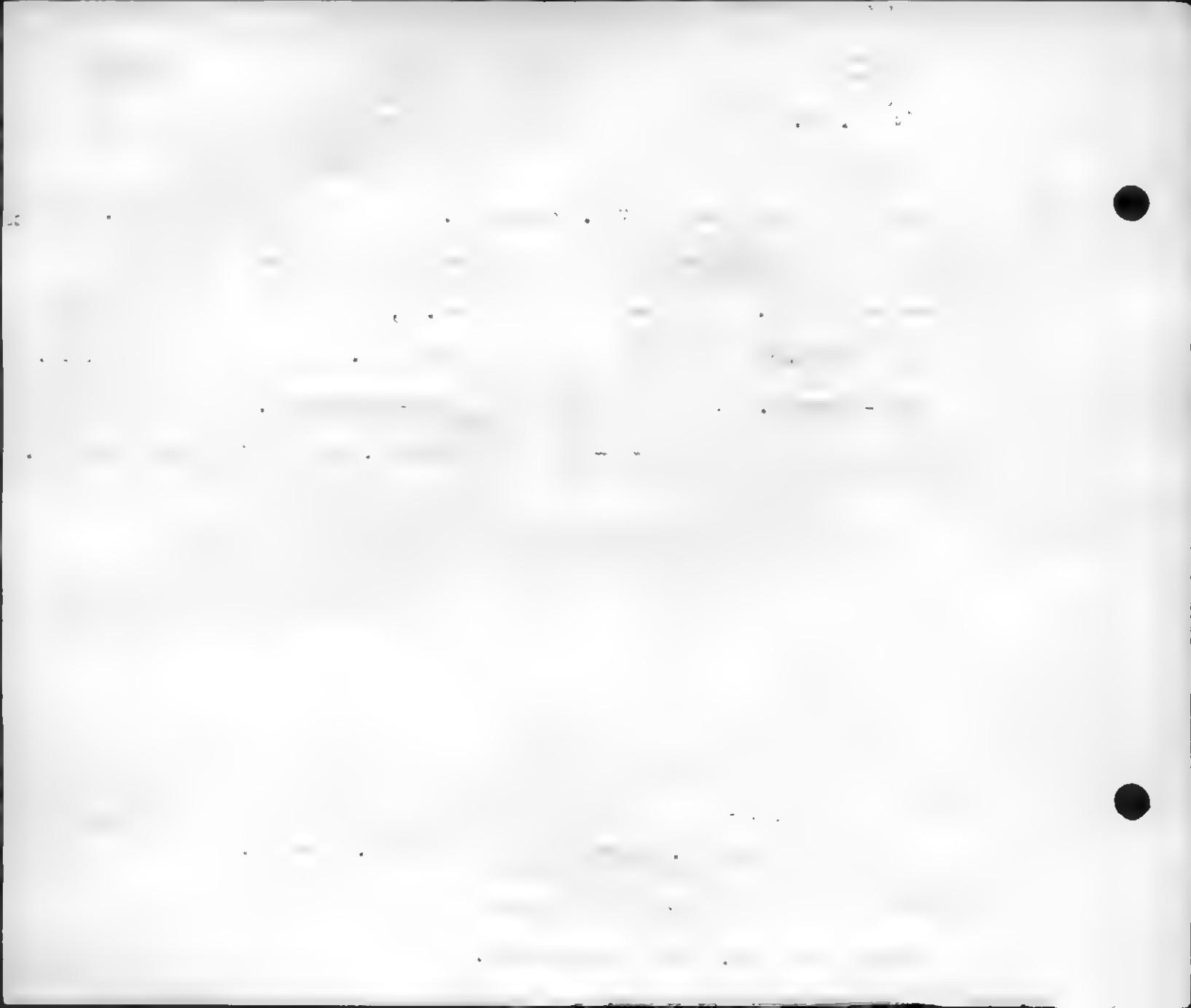
CERTIFICATE OF DEATH

06413

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore, Md.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Neck Nursing Home 1002 N. Rolling		d STREET ADDRESS Rd.		e S' RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Margaret	Middle 	Last Staup	4. DATE OF DEATH May 3,	Month May	Day 3	Year 67	
S SEX Female	6. COLOR OR RACE Cauc.	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B DATE OF BIRTH Nov. 5, 1902	9 AGE (In years 1st birthday) 84	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS Days 	Hours 	Min.
10. USUAL OCCUPATION (Give kind of work done during most working life even if retired) Clerical Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Balto. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME late- James C. Ball		14. MOTHER'S MAIDEN NAME late- Margaret A.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-36-6755		17. INFORMANT Miss Mary A. Ball		Address 512 Charing Cross Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1/10X</i>		<i>Carcinomatosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	DUE TO (c)	<i>Carcinoma of the breast</i>		2 months			
						1			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 		(County) 	(State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to May 3, 1967 , that (I) (we) last saw the deceased alive on April 30 1967 , and that death occurred at 5:15 P.M. from causes and on the date stated above.									
22a. SIGNATURE <i>Martin Singewald</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 5/4/67			
22c. PHYSICIAN'S NAME (Type) Dr. Martin L. Singewald		22d. ADDRESS 11 E. Chase St.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 6, 1967		23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		23d. LOCATION (City or Town) Baltimore Maryland		(County) 	(State)
24. FUNERAL DIRECTOR Witzke Funeral Dir. 4101 Edmondson Ave.		ADDRESS		25a. REC'D BY REGISTRAR MAI 8 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 (4) 25M 1/67									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.



VR A15 (4)
20 M 1/68

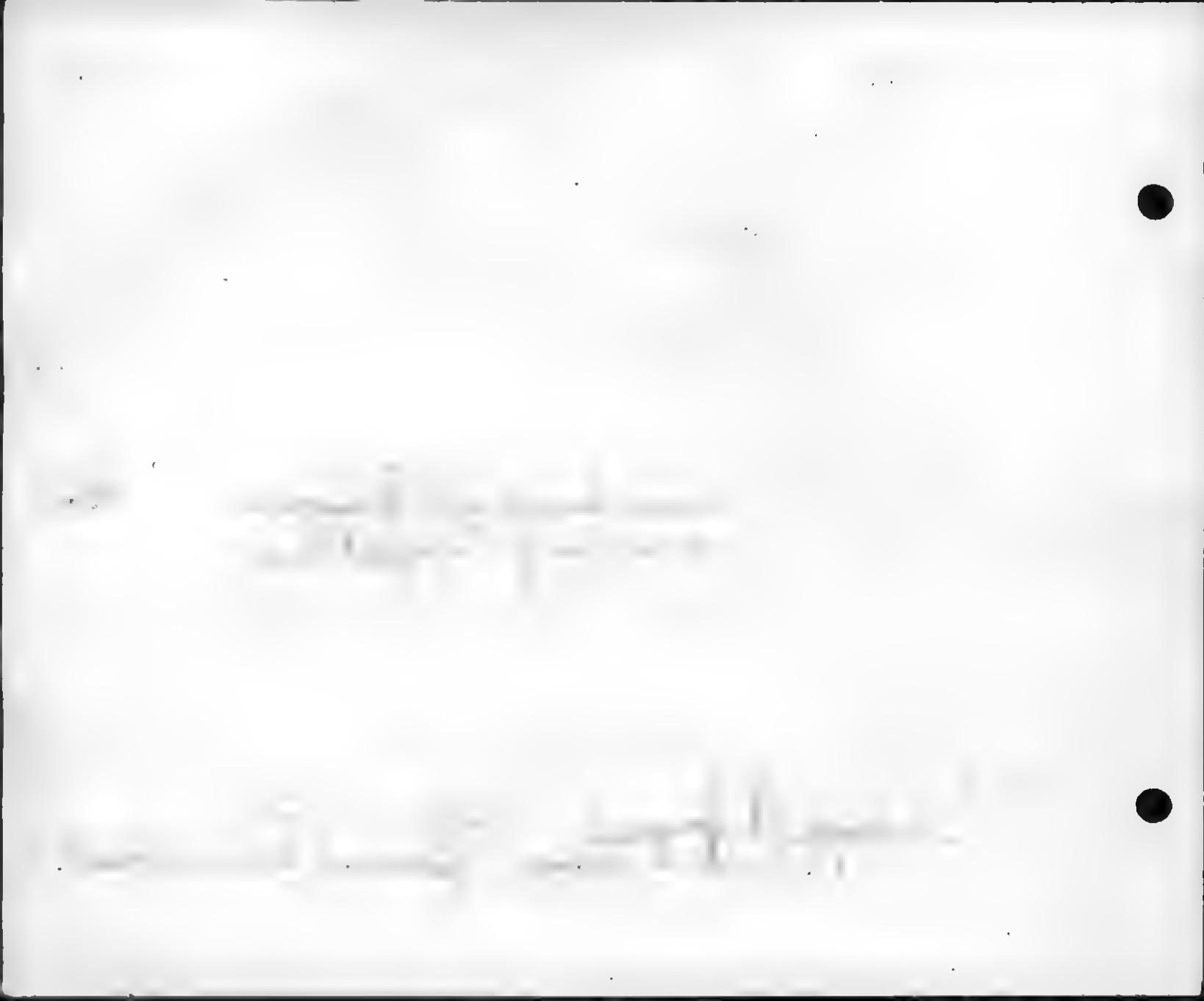
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06425

CERTIFICATE OF DEATH

VC 115

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	c. LENGTH OF STAY IN lb 3 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 915 Stiles Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Suzanne Paulette STEIN	First Suzanne	Middle Paulette	4. DATE OF DEATH 5 21 19 67
5. SEX Female	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-63
10a. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13. FATHER'S NAME Harry John Stein		14. MOTHER'S MAIDEN NAME Eleanor Mary Cucco	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	17. INFORMANT Address Rosewood Records, Owings Mills, Maryland
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
Acute Aspirational Pneumonia Microcephaly Congenital			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that W.F. Jones (this hospital) saw the deceased alive on May 21 1967 , and that death occurred at 8:25 A.M. from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones			
22c. PHYSICIAN'S NAME (Type) K. Richard A. Jones		22d. ADDRESS Rosewood State Hospital	22b. DATE SIGNED May 24 1967
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-22-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS HOLY ROSARY CEM.	23d. LOCATION (City or Town) (County) (State) BALTO. CO. MD.
24. FUNERAL DIRECTOR Wm Fialkowski 2007 EASTERN Ave.	25a. RECEIVED BY REGISTRAR DATE MAY 24 1967	25b. REGISTRAR'S SIGNATURE James J. Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96428

CERTIFICATE OF DEATH

1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb 25 yrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 124 Greenridge Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		
3. NAME OF DECEASED (Type or print) Carl First: A. Middle: Stoutenburg		d. STREET ADDRESS 124 Greenridge Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX M	6. COLOR OR RACE W.	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-24-1903	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Mgr.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Slicing M. Co		
11. BIRTHPLACE (County & State, or foreign country) Bloomville, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Stoutenburg		14. MOTHER'S MAIDEN NAME Emma Messick		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. 1919-1922		16. SOCIAL SECURITY NO. 070 03 8659		
17. INFORMANT Mable Stoutenburg		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DISEASE DUE TO (c)		
		INTERVAL BETWEEN ONSET AND DEATH 10 MIN		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APR 23, 1967, to MAY 1, 1967, that (I) (we) last saw the deceased alive on APR 23, 1967, and that death occurred at 850 M, from causes and on the date stated above.		22b. DATE SIGNED May 2, 1967		
22c. PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski, M. D.		22d. ADDRESS 206 N. Pennsylvania Avenue (21204)		
23a. BURIAL, CREMATION, REMOVAL (Specify) May 5, 67		23b. DATE THEREOF May 5, 67		23c. NAME OF CEMETERY OR CREMATORIUM Dulaney Valley
23d. LOCATION (City or Town) Cockeysville, Balto, Md.		23e. (County) (State)		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Md. 21204		ADDRESS Wm. Cook-Brooks Towson, Md. 21204		25e. REC'D BY REGISTRAR MAY 5 1967
				25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06427

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Roxbury, West Baltimore</i> <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c. LENGTH OF STAY IN lb						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore Co. General Hospital</i>		e. STREET ADDRESS <i>3703 Copley Rd.</i>						
f. NAME OF DECEASED (Type or print) <i>Bernice L. Criss</i>		First	Middle					
g. SEX <i>F.</i>		h. COLOR OR RACE <i>Negro</i>	i. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
j. B. DATE OF BIRTH <i>11-10-1914</i>		k. DATE OF DEATH <i>5 10 1967</i>						
l. AGE (In years lost birthday) <i>52 yrs</i>		l. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	m. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>					
n. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		n. 10b. KIND OF BUSINESS OR INDUSTRY <i>Social Security</i>						
o. 11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>		p. 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
q. 13. FATHER'S NAME <i>Samuel G. Criss</i>		r. 14. MOTHER'S MAIDEN NAME <i>MARTha L. Criss</i>						
s. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		t. 16. SOCIAL SECURITY NO <i>219-28-5223</i>						
u. 17. INFORMANT <i>Mr. Harold Street</i>		v. ADDRESS <i>3703 Copley Rd.</i>						
w. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b). DUE TO lost. (c)		x. INTERVAL BETWEEN ONSET AND DEATH <i>months</i>						
y. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) z. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 19 <i>66</i> , to <i>May 10, 1967</i> , that (II) (we) last saw the deceased alive on <i>May 10, 1967</i> , and that death occurred at <i>2:00 P.M.</i> from causes and on the date stated above.								
22a. SIGNATURE <i>David J. Miller</i>		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. MEDICAL CERTIFICATION 22d. DATE SIGNED <i>May 10-67</i>				
22e. PHYSICIAN'S NAME (Type) <i>David J. Miller</i>		22f. ADDRESS <i>Linson Rd Owings Mills Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-13-67</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Arbutus Mem. Park</i>		23d. LOCATION (City or Town) <i>Arbutus</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Morton & Dyett F.H.</i>		25a. ADDRESS <i>1701 Laurens St.</i>		25b. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
				DATE <i>MAY 12 1967</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

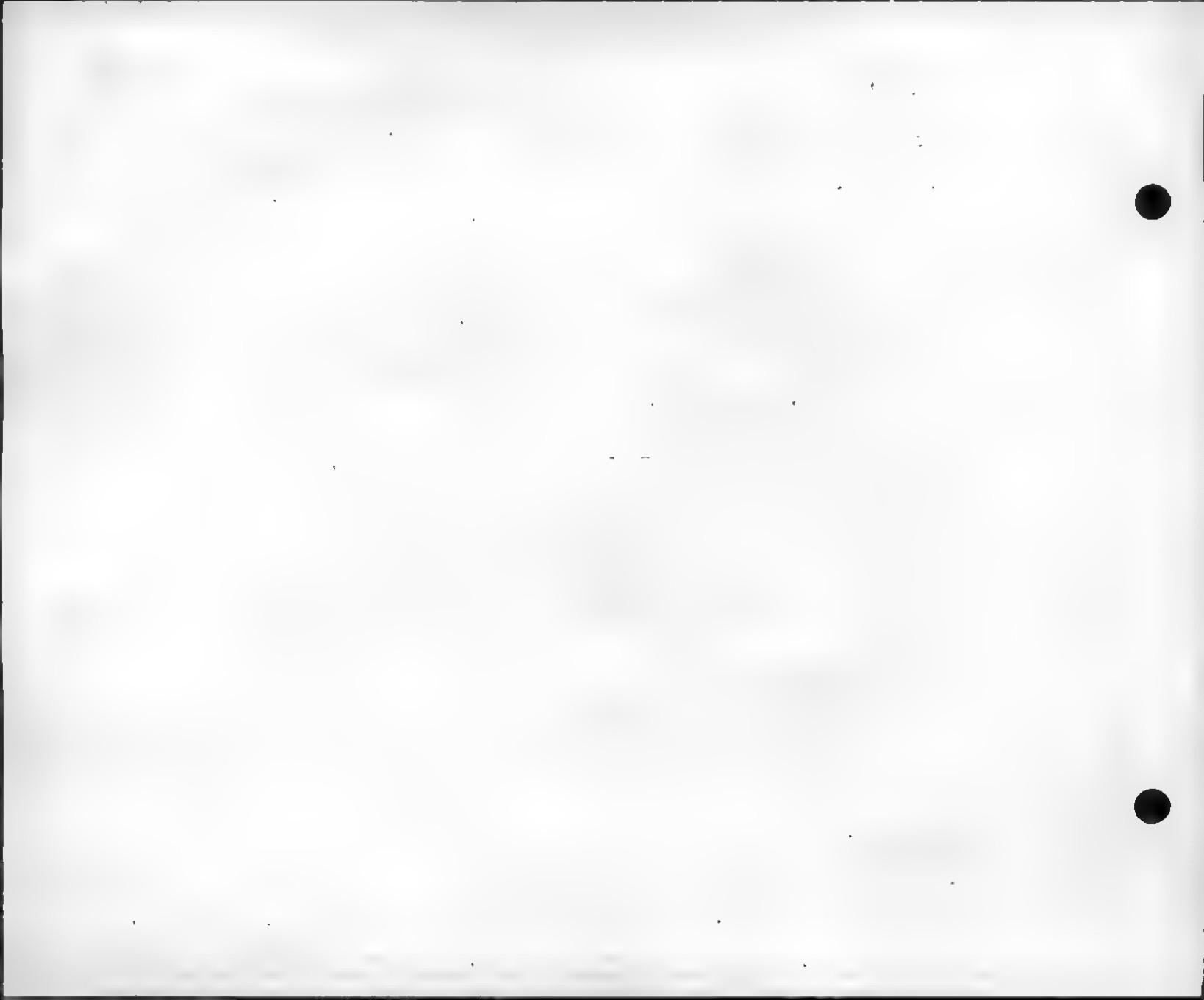
06423

CERTIFICATE OF DEATH

06418

1 HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.
2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Stoneleigh				Edmondson Baltimore 21212				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
6207 Beechwood Road		6207 Beechwood Road						
3. NAME OF DECEASED (Type or print)		First Susanna	Middle M	Lost Striebel	4 DATE OF DEATH Month May Day 4 Year 1967			
S. SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 30, 1877	9 AGE (In years last birthday) yrs 89	10. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Germany	12 CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during past of work w/never if retired) Housewife								
13. FATHER'S NAME Lorenz Schiller		14. MOTHER'S MAIDEN NAME Margaret Wehrwein		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-01-4166		17. INFORMANT Mrs. Gretchen M. Harrison same		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour g.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5-4, 1967, to 5-4, 1967, that (I) (we) last saw the deceased alive on 5-4, 1967, and that death occurred at 1A M, from causes and on the date stated above.								
22a. SIGNATURE W.M. Smith		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 5-5-67
22c. PHYSICIAN'S NAME (Type) W.M. Smith		22d. ADDRESS 630-5 THE ALMERS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/67.		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc Baltimore, Md.		25a. RECD. BY REGISTRAR DATE MAY 8 1967						25b. REGISTRAR'S SIGNATURE Charles George
VR A15 (4) 20 M 1/66								



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

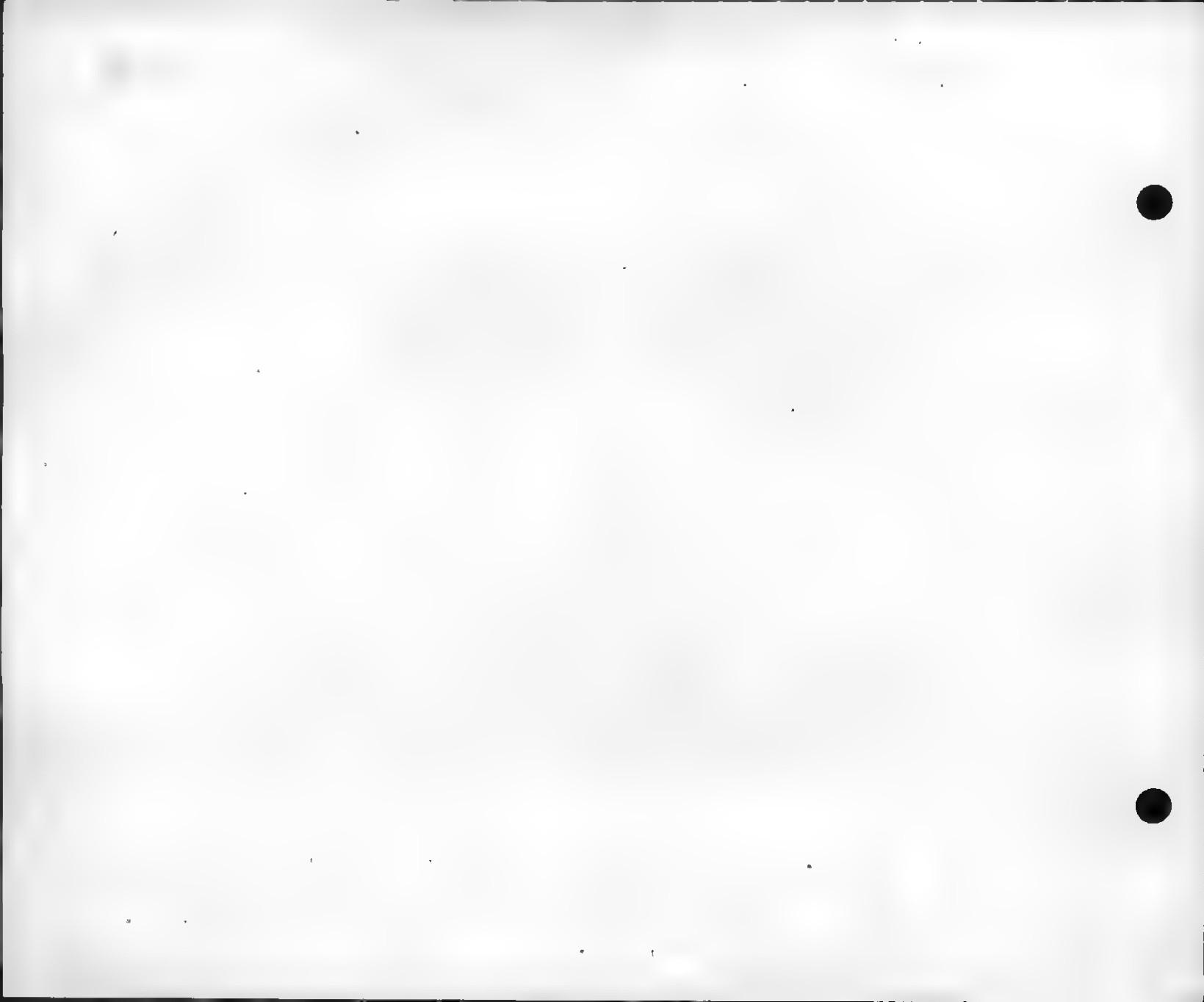
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06430

CERTIFICATE OF DEATH

06419

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1817 Ellinwood Road			d. STREET ADDRESS 1817 Ellinwood Road		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)		First MILDRED	Middle JOSEPHINE	Last STUPRICH	4 DATE OF DEATH 5/7/67
5 SEX female	6 COLOR OR RACE white	7 MARRIED WIDOWED	8 NEVER MARRIED DIVORCED	9 AGE (In years last birthday) 52 yrs	10 IF UNDER 1 YEAR Months 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b KIND OF BUSINESS OR INDUSTRY Holland House		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
13 FATHER'S NAME Frank Kouglo			14. MOTHER'S MAIDEN NAME unknown		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 217-26-7383		17 INFORMANT Oscar Stuprich, 1817 Ellinwood Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Metastatic carcinoma of the breast / mostly lungs & liver</i> DUE TO (c) <i>Lungs & liver</i> DUE TO					
INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>June 1964</i>	
20f (City or town) <i>Philadelphia</i>		(County) <i>May</i>		(State) <i>PA</i>	
21 I certify that (I) (this hospital) attended the deceased from <i>June 1964</i> , to <i>April 20 1967</i> , that (I) (we) last saw the deceased alive on <i>Aug 19 64</i> , and that death occurred at <i>10 A.M.</i> from causes and on the date stated above.					
22a. SIGNATURE <i>Dr. John Geldrich</i>		M.D. <input type="checkbox"/> ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) Dr. John Geldrich		22b. DATE SIGNED <i>May 9/1967</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/11/67		23c NAME OF CEMETERY OR CREMATORIAL ADDRESS Gardens of Faith Cem	
23d LOCATION (City or Town) Baltimore, Md.		(County) <i>MD</i>		(State) <i>MD</i>	
24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		ADDRESS		25a. REC'D BY REGISTRAR MAY 11 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

36431

CERTIFICATE OF DEATH

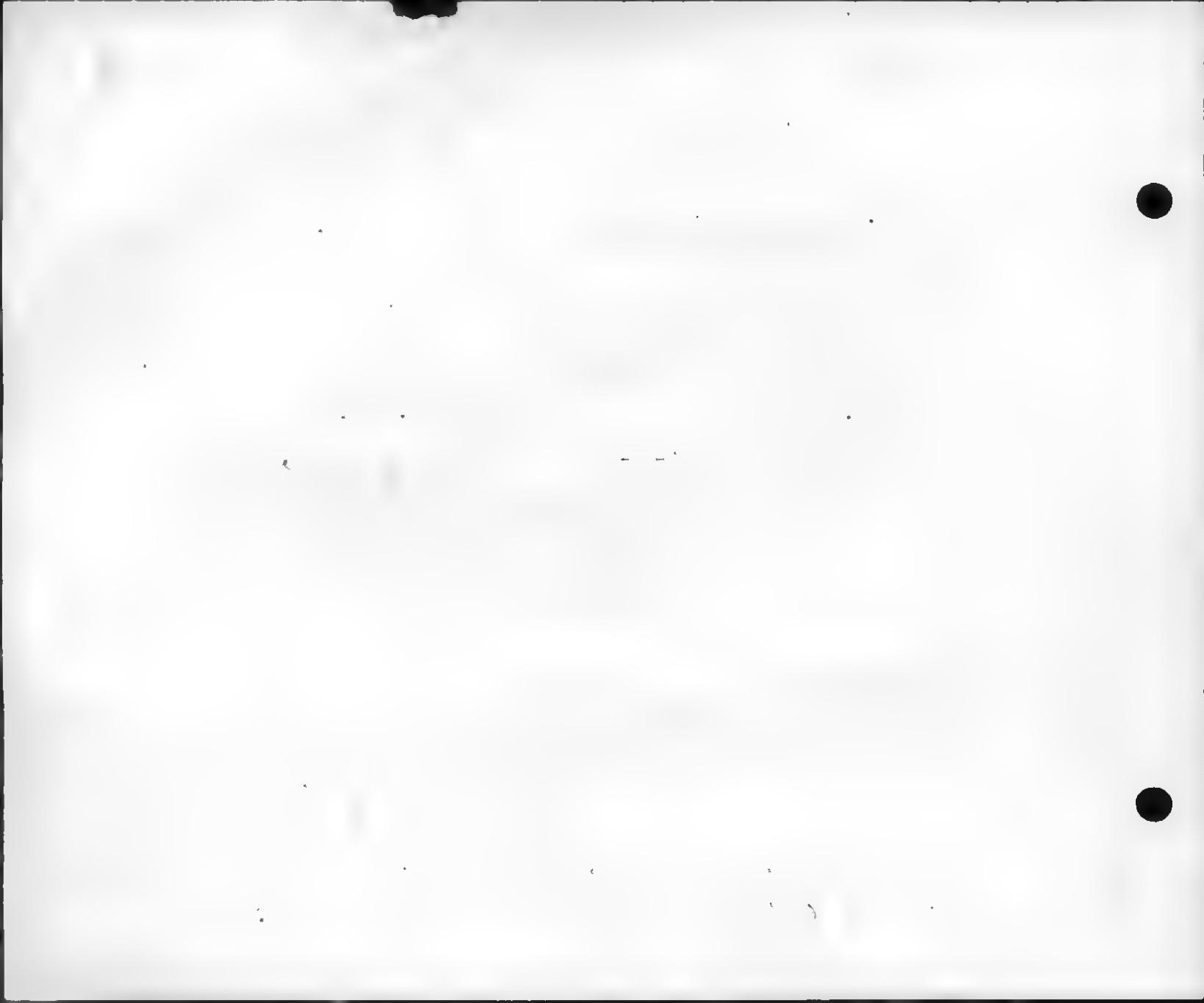
06428

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS 1912 E. Madison Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma First M Middle SUPIK		4. DATE OF DEATH Month May Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-08
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY Social Security Agency	
13. FATHER'S NAME Charles A. Supik		14. MOTHER'S MAIDEN NAME Emma H. Kozlovsky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-10-8473	
17. INFORMANT Edward Supik, brother		Address Box 67 Route 1, Hyde, Maryland 21082	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Acute hemorrhagic pancreatitis.	
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b)			
DUE TO last (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Towson (County) Md. (State)			
21. I certify that (I) (this hospital) attended the deceased from May 27 , 19 67 , to May 28 , 19 67 , that (I) (we) last saw the deceased alive on May 28 19 67 , and that death occurred at 7:10 P.M. from causes and on the date stated above.			
22a. SIGNATURE Juana S. Cockburn		22b. DATE SIGNED May 29, 1967	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Holy Redeemer Cemetery
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13		25a. REC'D BY REGISTRAR DATE JUN 1 1967	25b. REGISTRAR'S SIGNATURE Juana S. Cockburn



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

000421

CERTIFICATE OF DEATH

PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN lb 1 week		Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8801 Harford Road		22 years		e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Balto. 21234 Parkville	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month
Rt. Rev. William J.			Sweeney	May	12 19 67
SEX	6 COLOR OR RACE	7 MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH	9 AGE (In years last birthday) 1901 66 68 yrs.
M.	W.			March 5 1900	IF UNDER 1 YEAR Months Days Hours Min
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		Ob KIND OF BUSINESS OR INDUSTRY Religious		11. BIRTHPLACE (County & State or foreign country) Baltimore Maryland	
13. FATHER'S NAME Dennis Sweeney		14. MOTHER'S MAIDEN NAME Mary Brennan		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Family Records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO COPD, asthma Arteriosclerotic Cardiovascular Disease (c) DUE TO with Coronary artery Disease.		Cause of Death Congestive heart failure COPD, asthma Arteriosclerotic Cardiovascular Disease with Coronary artery Disease.		INTERVAL BETWEEN ONSET AND DEATH 30-45 min 15-20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) O/D. Myocardial Infarction				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE Vicente P. Ang		M.D. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED May 13, 1967		
22c. PHYSICIAN'S NAME (Type) Vicente P. Ang		22d. ADDRESS St. Joseph Hospital			
23a. BURIAL, CREMATION, REMAINS <input type="checkbox"/> REMAINS <input type="checkbox"/>		23b. DATE THEREOF 5-17-1967		23c. LOCATION (City or Town) Baltimore (County) Md. (State)	
24. FUNERAL DIRECTOR C. F. Evans & Son		ADDRESS 8802 Harford Rd.		25a. REC'D. BY REGISTRAR DATE MAY 18 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

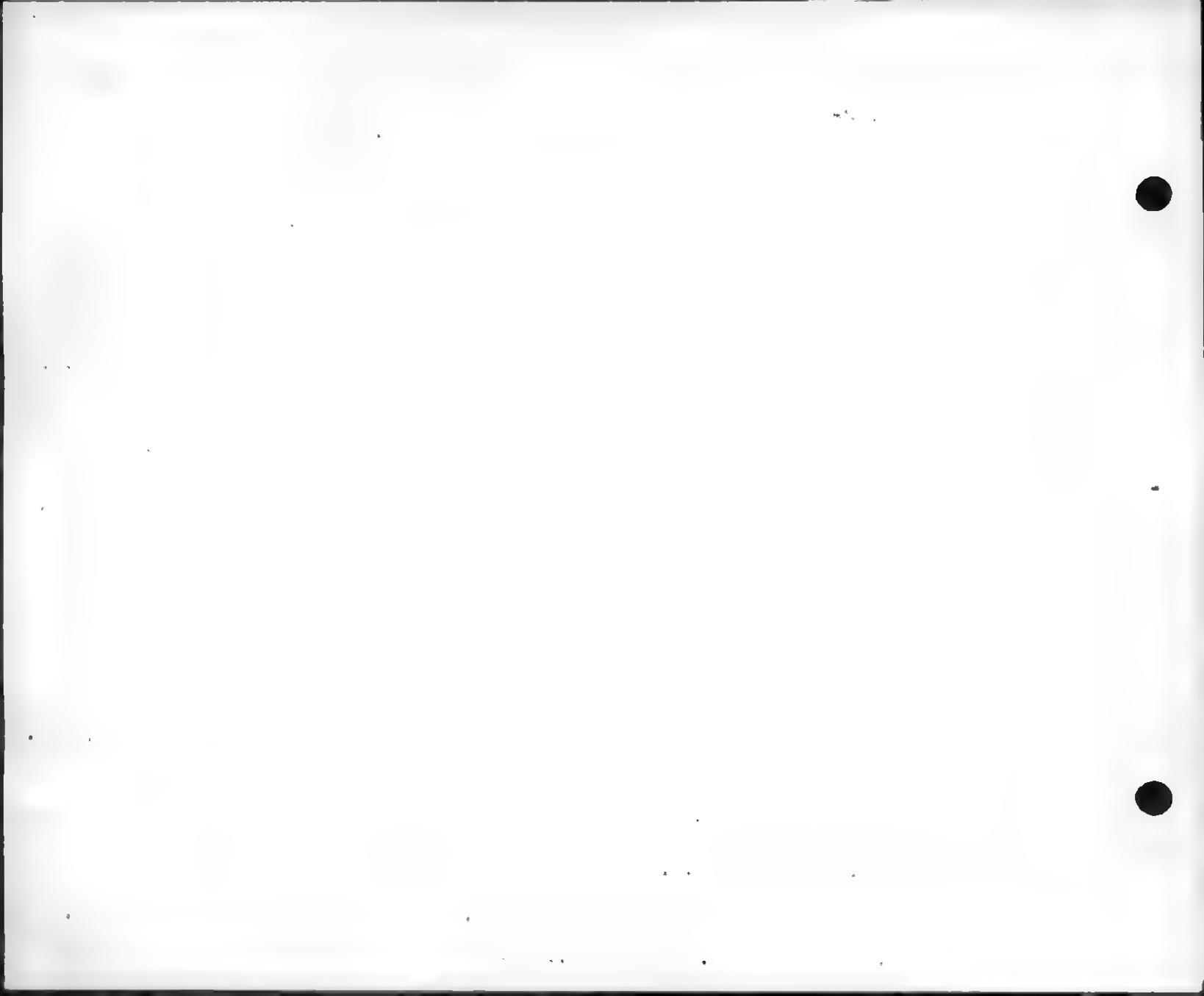
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

06433

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-22

1 PLACE OF DEATH a COUNTY <i>Baltimore</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <i>Md.</i>	
b CITY OR TOWN (If outside corporate lim ls, write RURAL and give nearest town) <i>Owings Mills</i>		c LENGTH OF STAY IN 1b <i>5 yrs.</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to g ve street address) <i>Rosewood State Hosp.</i>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>LELAND</i>		First <i>EDWARD</i>	Middle <i>SWICK</i>
4 DATE OF DEATH <i>5 26 1967</i>	Month Year Day	Month	Year
5 SEX Male <i>White</i>	6 COLOR OR RACE White	7 MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <i>1-11-55</i>	9 AGE (In years last birthday) <i>12 yrs</i>	10 IF UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) <i>Dependent</i>	10b KIND OF BUSINESS OR INDUSTRY <i>none</i>	11 BIRTHPLACE (State or foreign country) <i>Allegany Co., Md.</i>	
13 FATHER'S NAME <i>Richard Lee Swick</i>	14. MOTHER'S MAIDEN NAME <i>Mildred Elizabeth Moss</i>	12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Rosewood Records, Owings Mills, Maryland</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asphyxia due to aspiration of cookie</i> DUE TO 9217 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>25 min.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Severe Mental Retardation with hyperactivity</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMAR Y OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Stuffed cookie in mouth and choked on cookie</i>	
20c TIME OF INJURY Month, Day, Year Hour 20 pm <i>5-26-1967</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg. etc.) <i>Holland Cottage, Rosewood St., Hosp.</i>	20f (City or town) (County) (State) <i>Owings Mills, Balto., Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D. D. Caples</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED <i>5-26-67</i>
EXAMINER'S NAME (Type) <i>D. D. Caples, M.D.</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county) <i>Cumberland, Allegany, Md.</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE THEREOF <i>5/29/67</i>	23c NAME OF CEMETERY OR CREMATORIUM <i>Sunset Memo. Pk.</i>	23d LOCATION (City or Town) (County) (State) <i>Cumberland, Allegany, Md.</i>
24 FUNERAL DIRECTOR <i>Philip B. Wendt 121 Mem. Ave., Cumb., Md.</i>	ADDRESS	25a REC'D BY REG STRR DATE <i>MAY 31 1967</i>	25b REGISTRAR'S SIGNATURE <i>Almonia Judge</i>
VR A15ME (5) 6M 1/66			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96434

CERTIFICATE OF DEATH

96423

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN TB		d. STREET ADDRESS 2683 West Park Drive 21207	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blanche		4. DATE OF DEATH May 16 1967	Month Day Year
S SEX Female	5. COLOR OR RACE White	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. BIRTHDATE 9/14/95		8. DATE OF BIRTH 71 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Row		14. MOTHER'S MAIDEN NAME Susan - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Florence A. Stump		Address 710 N. Chapelgate Lane 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive CARDIOVASCULAR Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Essential Hypertension DUE TO last (c)			
INTERVAL BETWEEN ONSET AND DEATH At least 20 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1 (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from February 27 1967 to MAY 16 1967 , that (I) (we) last saw the deceased alive on MAY 17 1967 , and that death occurred at 8:20 AM , from causes and on the date stated above			
22a. SIGNATURE Melvin N Borden		22b. DATE SIGNED 5/16/67	
22c. PHYSICIAN'S NAME (Type) Melvin Borden WI 5-6680		22d. ADDRESS 5000 BALTO NATIONAL Pike 21229 600 N. Chapel Gate Lane	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67	
23c. NAME OF CEMETERY OR CREMATORIAL Western Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard		25a. ADDRESS 21229 4107 Wilkens Ave.	
		25b. REGISTRAR'S SIGNATURE MAY 18 1967 Charles Judge	



X K 12
96435

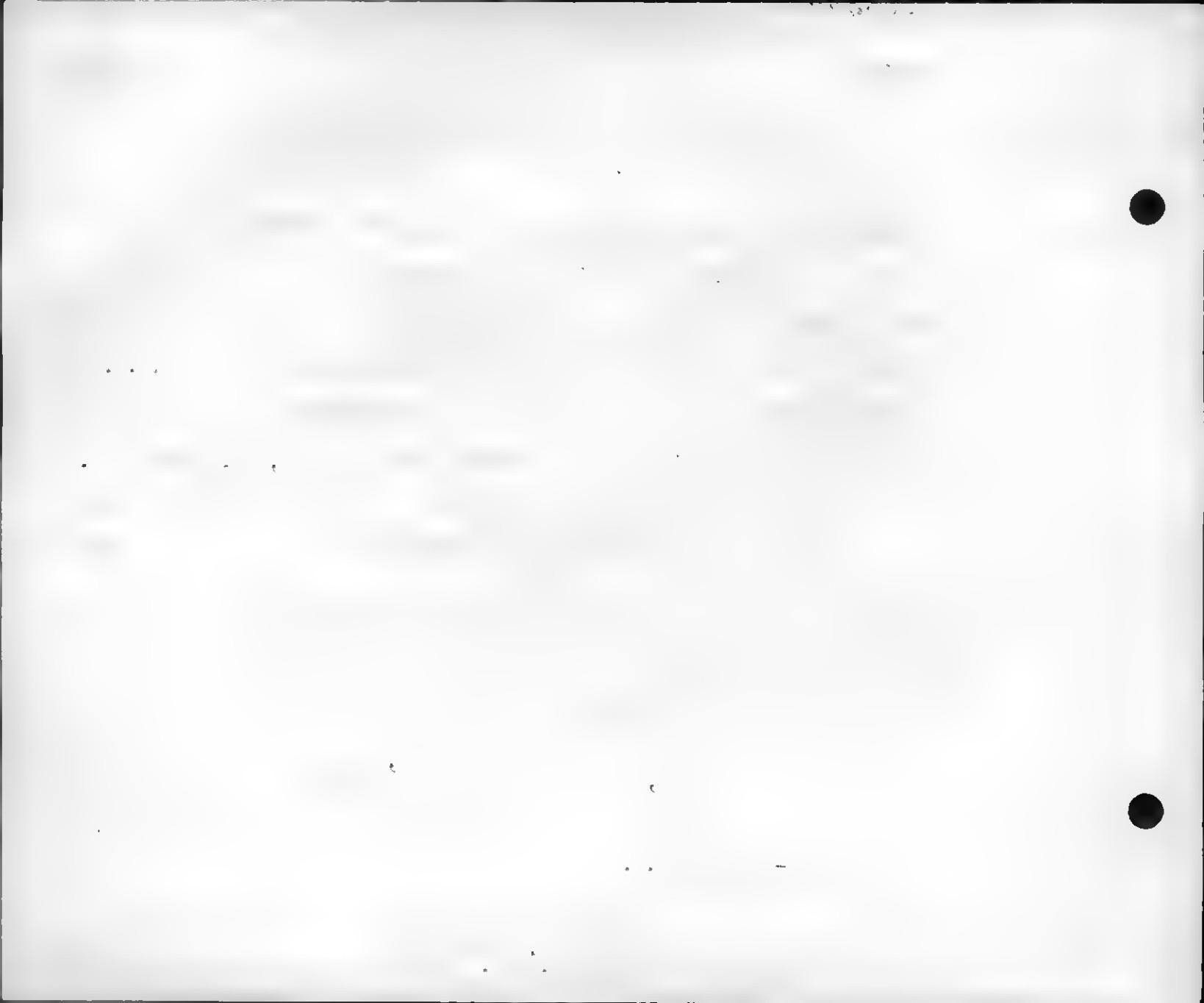
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06424

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b 83 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 1313 WEST MULBERRY STREET		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM NMI TALLEY		First	Middle	Last	4. DATE OF DEATH MAY 27, 1967	Month	Doy	Year
SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/95	9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	11. BIRTHPLACE (County & State or foreign country) CULPEPPER, VIRGINIA	
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME GEORGE TALLEY				14. MOTHER'S MAIDEN NAME BELLE PARKER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> YES WWI				16. SOCIAL SECURITY NO. 218 05 78 89	17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). CHRONIC HEART FAILURE				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4400				DUE TO (b) AFTERIOSCLEROSIS HEART DISEASE DUE TO (c)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20. MEDICAL CERTIFICATION				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, offce bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 5, 1967 to MAY 27, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 27, 1967 , and that death occurred at 8:50 A.M. , from causes and on the date stated above.				22b. DATE SIGNED 5/27/67				
22a. SIGNATURE. <i>Zui-Sun Tao</i>				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/27/67			
22c. PHYSICIAN'S NAME (Type) ZUI-SUN TAO, M.D.				22d. ADDRESS VAH, FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/31/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR ADOLPHUS HALSTEAD FUNERAL HOME				ADDRESS 1206 W. North Ave BALTO., MD.		25a. REC'D BY REGISTRAR J Charles Judge		
						25b. REGISTRAR'S SIGNATURE MAY 29 1967		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

JE 25

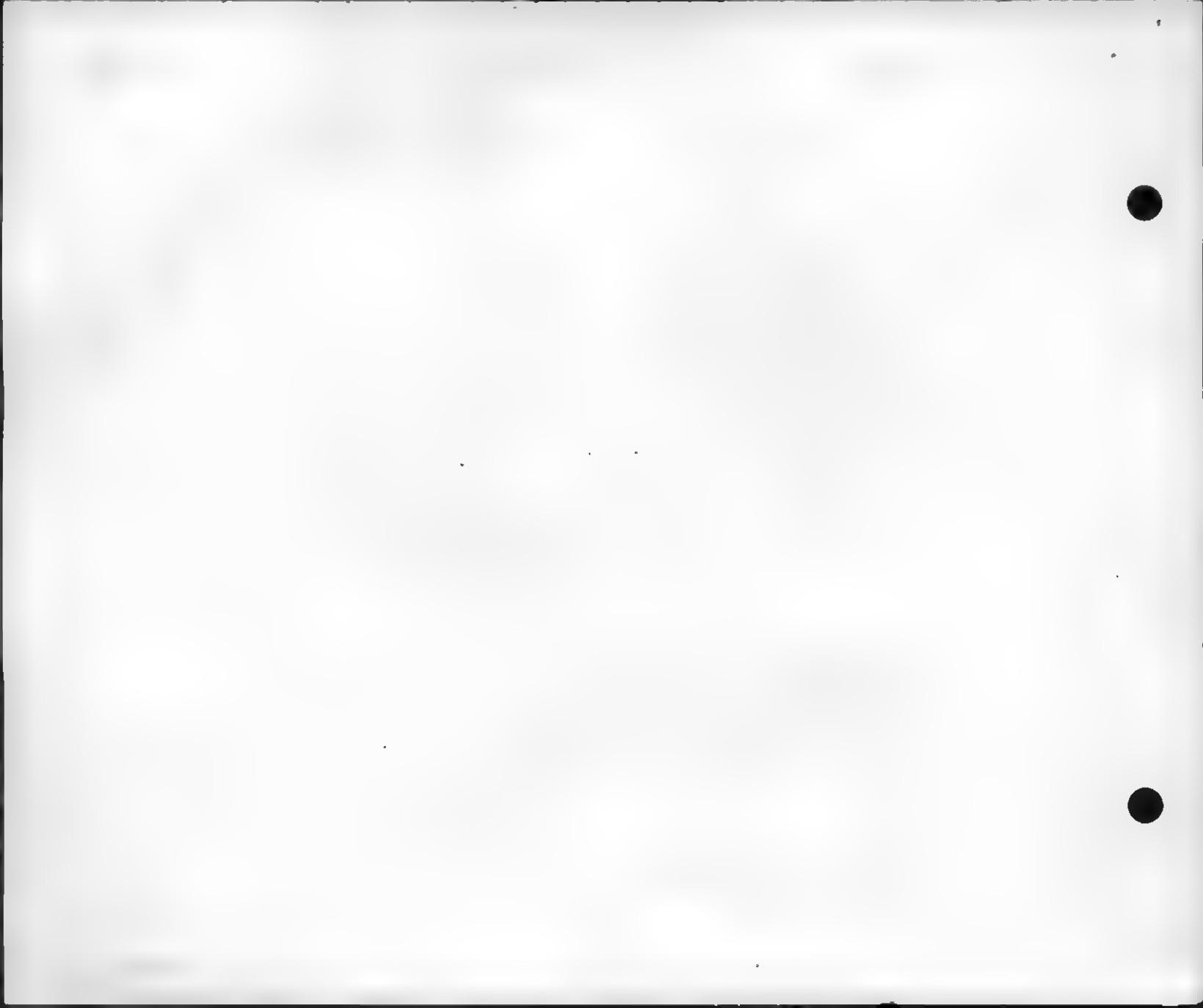
26436

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, air removal, and in any event, within 72 hours after death.

M

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE	
BALTIMORE MARYLAND		MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
BALTIMORE		BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
6001 UPDALE COURT		6001 UPDALE COURT	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First	Middle
MARTIN		TANNER	
4 SEX	5 COLOR OR RACE	6 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7 DATE OF BIRTH
MALE	WHITE		12/25/1892
8 AGE (in years last birthday)		9 UNDER 1 YEAR IF UNDER 24 HRS	
74 yrs		Months	Days Hours Min.
10a US. AL OCCUPATION (Give kind of work done during most of working life, even if retired)		11 BIRTHPLACE (County & State, or foreign country)	
RETIRED-RAILROAD		ATLANTIC COAST LINE BROOKLYN, NEW YORK	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
HENRY TANNER		SARAH GELLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
YES ARMY WW I		718-12-1116	
17 INFORMANT		Address	
MRS. SYBIL TANNER WHITE, 6001 UPDALE COURT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) Acute myocardial infarction 1 hr			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO (c) Arteriosclerotic cardiovascular disease 6 mos			
DUE TO (d) with prior myocardial infarction Jan 67			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 1963 to May 17, 1967, that (I) (we) last saw the deceased alive on May 12, 1967, and that death occurred at 10P M, from causes and on the date stated above.			
22a SIGNATURE <i>DR. MARVIN DAVIS</i>		22b DATE SIGNED May 15, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 6512 LIBERTY ROAD	
23a BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		23b DATE THEREOF 5/16/67	
23c NAME OF CEMETERY OR CREMATORIAL ADDRESS HERREW FRIENDSHIP		23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24 FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		25a. REC'D BY REGISTRAR DATE MAY 19 1967	
		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
<p>36437</p> <p>1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKTON</p> <p>c. LENGTH OF STAY IN BD Life</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #1</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKTON</p> <p>d. STREET ADDRESS RFD #1</p>				<p>8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) SARAH ELISIA THOMPSON</p>			<p>First SARAH Middle ELISIA Last THOMPSON</p>			<p>4. DATE OF DEATH MAY 26 1967</p>		<p>Month MAY Day 26 Year 1967</p>			
<p>5. SEX Female</p>		<p>6. COLOR OR RACE Cau.</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 6-22-1885</p>		<p>9. AGE (in years last birthday) 81 yrs.</p>		<p>10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY Home</p>				<p>11. BIRTHPLACE (State or foreign country) Balto. Co. Maryland</p>			
<p>13. FATHER'S NAME JOSHUA Wheeler</p>				<p>14. MOTHER'S MAIDEN NAME Rachel HARE</p>				<p>12. CITIZEN OF WHAT COUNTRY? USA</p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p>				<p>16. SOCIAL SECURITY NO. 219-30-83580</p>				<p>17. INFORMANT Mrs. Ethel R. Price</p>			
								<p>Address 149 Lib. City St., Westminster, Md.</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1821 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)</p> <p>DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>											
<p>INTERVAL BETWEEN ONSET AND DEATH</p>											
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>				<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. May 19 p.m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) PARKTON</p>		<p>(County) MD</p>		<p>(State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE A. M. France</p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>				<p>22. DATE SIGNED 5/21/67</p>			
<p>EXAMINER'S NAME (Type) A. M. France</p>				<p>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>				<p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>Address (Street, city, town, or county) PARKTON, MD</p>											
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>		<p>23b. DATE THEREOF May 29, 1967</p>		<p>23c. NAME OF CEMETERY OR CREMATORIAL CEMETERY MT. CARMEL Cemetery</p>		<p>23d. LOCATION (City, town or county) PARKTON</p>		<p>(State) MD</p>			
<p>24. FUNERAL DIRECTOR John E. Goff</p>				<p>ADDRESS Hampstead, MD</p>				<p>25a. REGD. BY REGISTRAR MAY 31 1967</p>		<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

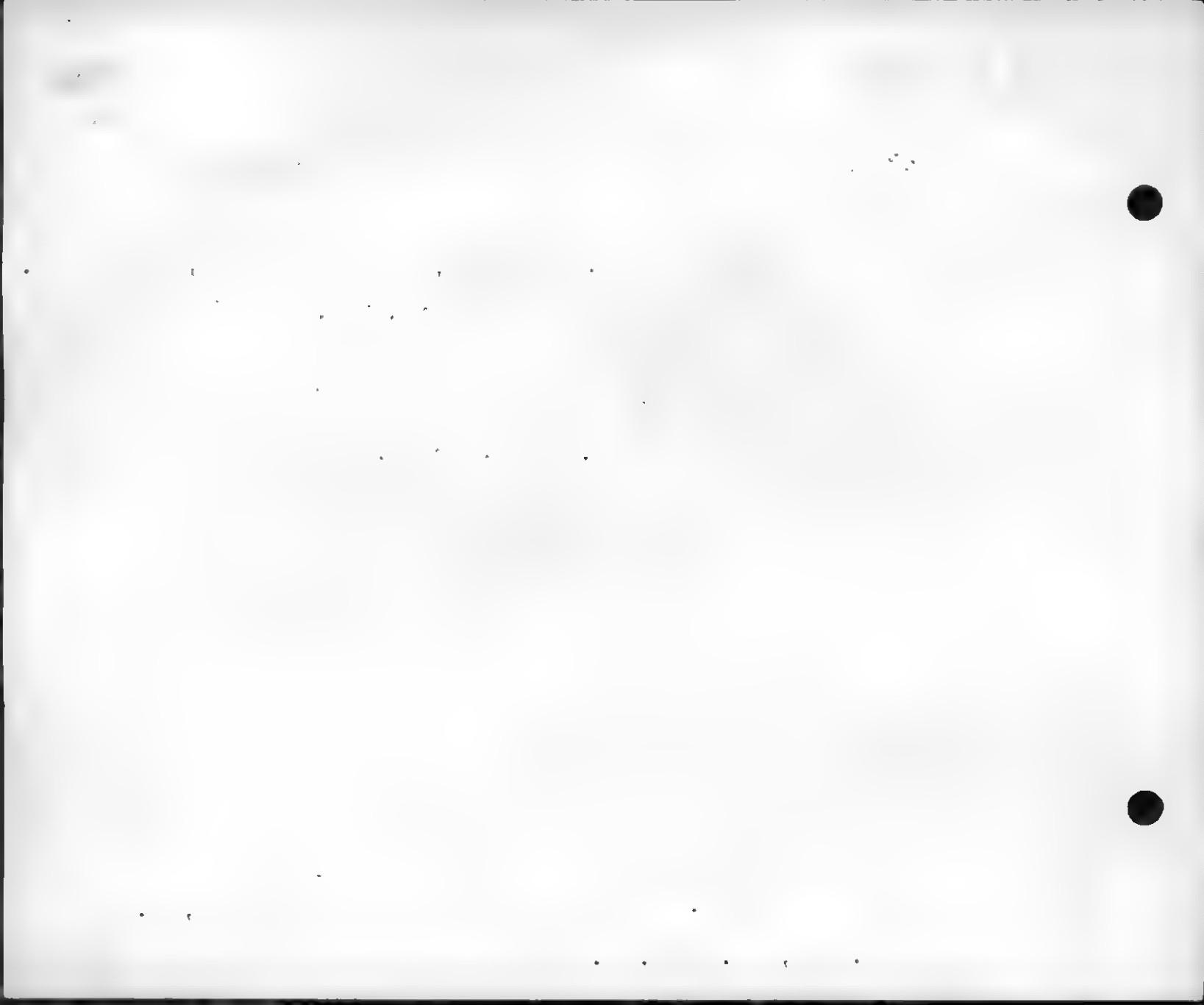
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 File # G-89579161 PC

CERTIFICATE OF DEATH

06438

06438

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2910 Onyx Road			d. STREET ADDRESS 2910 Onyx Road e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First RANDOLPH Middle H. Last THRASHER, SR.		4. DATE OF DEATH May 19,		Month Day Year 19 67.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH October 5, 1906	9. AGE (in years last birthday) 60 yrs IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Letter Carrier		10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME William Thrasher			14. MOTHER'S MAIDEN NAME Eleanor Simmens		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Unk.		17. INFORMANT Mrs. Verna L. Thrasher Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 13 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part i or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3. 23, 1954, to 5. 19, 1967, that (I) (we) last saw the deceased alive on 5. 4, 1967, and that death occurred at 4 P.M., from causes and on the date stated above.					
22a. SIGNATURE <i>S. E. L. S.</i>		MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5. 20 67	
22c. PHYSICIAN'S NAME (Type) DR. JES. SKLOVSK		22d. ADDRESS 7127 Highland St. Baltimore 24			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/67.	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery	23d. LOCATION (City or Town) Baltimore, Md. (County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. REC'D BY REGISTRAR MAY 22 1967	25b. REGISTRATION NUMBER jessie j. ruck
VR A15 (4) 25M 1/67				DATE MAY 22 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

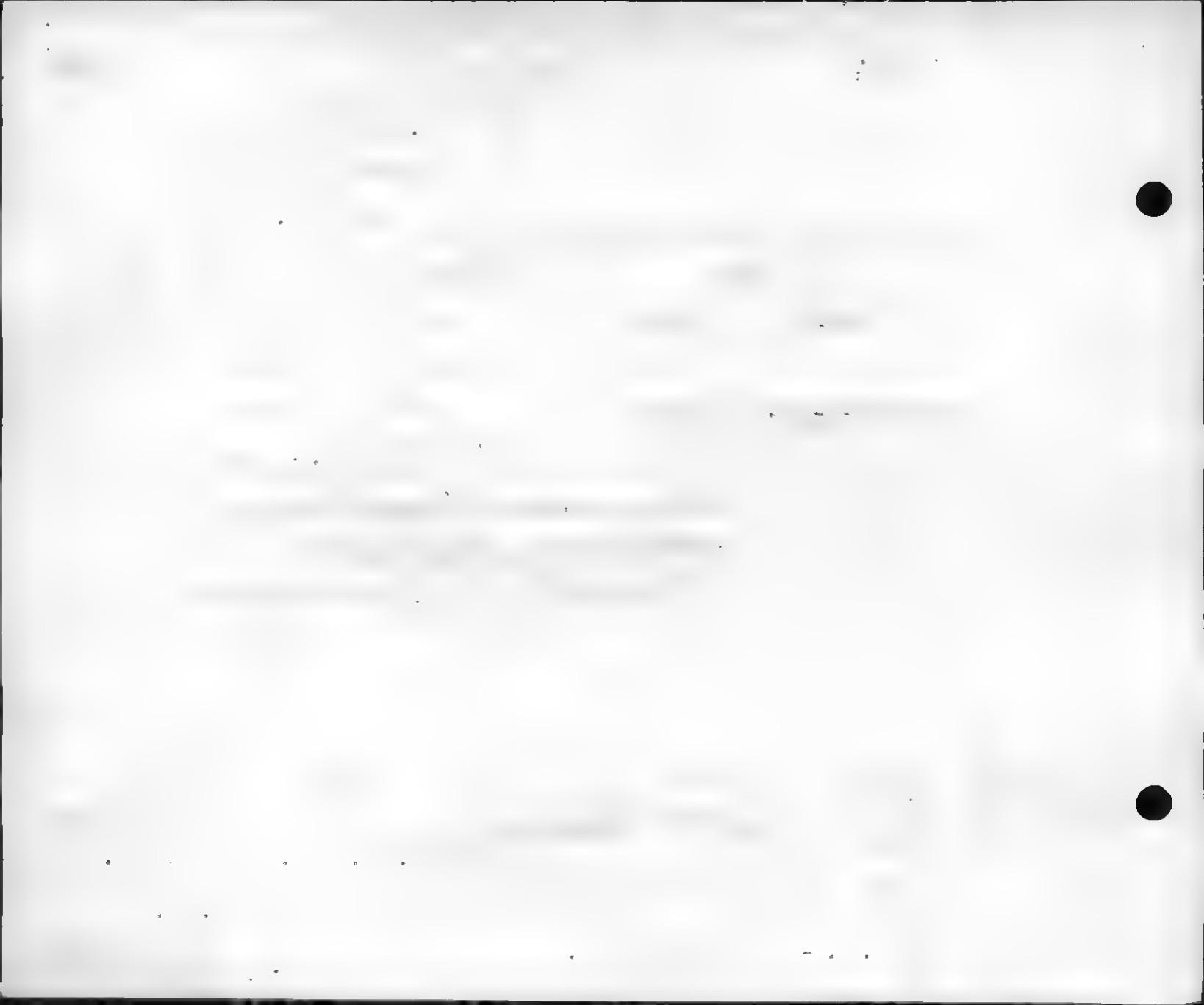
06439

CERTIFICATE OF DEATH

F-128

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

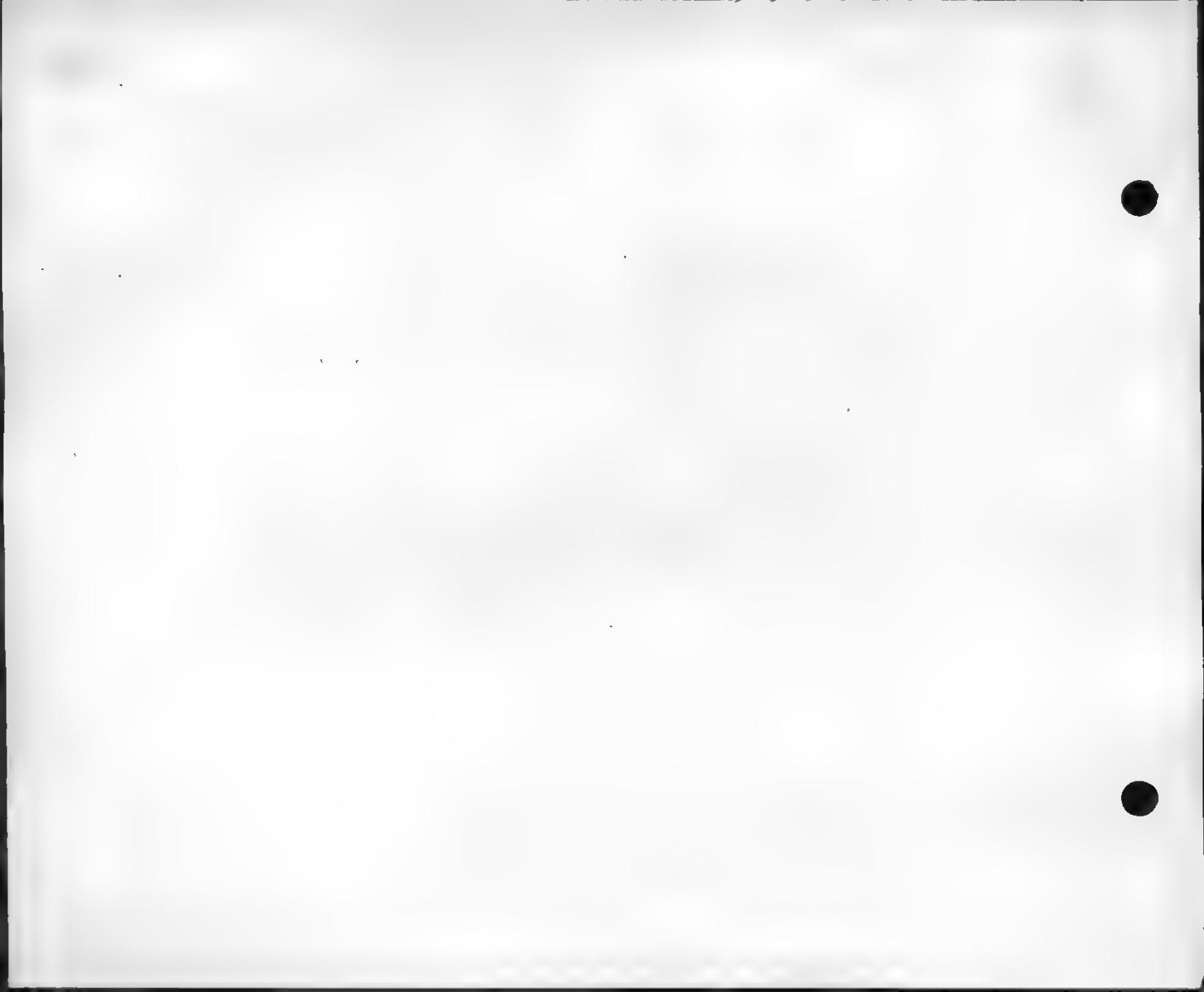
1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>1523 Kirkwood Rd.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore County General Hospital.</i>				d. STREET ADDRESS <i>1523 Kirkwood Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Eva F. Koenekoe</i>		First	Middle	Last	4 DATE OF DEATH <i>5 29 1967</i>	Month	Year
S. SEX <i>F.</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-6-95</i>	9. AGE (in years last birthday) <i>72 yrs</i>	10 UNDER 1 YEAR Months <i>15</i>	11 UNDER 24 HRS Days Hours Min <i>29 19 67</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPL.ACE (County & State, or foreign country) <i>Baltimore Maryland</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Koeneke</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Dreschler</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Mrs Lena Keerber</i>		Address <i>1521 Clairidge Rd. - 21207</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>O Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>O Pulmonary Embolism</i> DUE TO (c) <i>O Pulmonary Embolism</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>0 days</i>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5-19, 1967</i> , to <i>5-29, 1967</i> , that (I) (we) last saw the deceased alive on <i>5-29, 1967</i> , and that death occurred at <i>2410 M</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>Stephen Lai</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>5/29/67</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>Balto. Co. Hosp., Old Court Rd.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6/1/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Witzke F. D. - 4101 Edmondson Ave.</i>		ADDRESS					
		25a. REC'D BY REGISTRAR DATE <i>MAY 31 1967</i>					
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Page 3 should be detached for use as the burial/transit permit. Then please file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <i>Maryland</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. LENGTH OF STAY IN 1D <i>MARYLAND</i>				b. COUNTY <i>Baltimore</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>131 Elinor Avenue</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Edward F. Tilling Sr.</i>				First <i>Edward</i>		Middle <i>F.</i>		Last <i>Tilling Sr.</i>		4. DATE OF DEATH <i>May 10 1967</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-28-1900</i>		9. AGE (In years last birthday) <i>66 yrs.</i>		10. IF UNDER 1 YEAR <i>Months Days Hours Min.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman-Waterfitter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Balto. City</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Illchester, Md.</i>			
13. FATHER'S NAME <i>Joseph V. Tilling</i>				14. MOTHER'S MAIDEN NAME <i>Lulu Marie Hanes</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DEC EASSED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>214-20-3426</i>				17. INFORMANT <i>Mary (Marie) C. Tilling-131 Elinor Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular</i>				INTERVAL BETWEEN ONSET AND DEATH <i>months</i>							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> <i>Bronchogenic carcinoma</i>				(b) <i>(c)</i>				yes?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ACVD & chronic & true fibroblastosis.</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Belair Rd Baltimore</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>June 9, 1967</i> , to <i>10 May, 1967</i> , that (I) (we) last saw the deceased alive on <i>9 May, 1967</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.				22b. DATE SIGNED <i>5-11-67</i>							
22a. SIGNATURE <i>John C. Miller</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) <i>JOHN C. MILLER</i>				22d. ADDRESS <i>2527 Belair Rd Baltimore Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-13-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Redeemer Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>John C. Miller Inc. - 6415 Belair Rd. - 21206</i>				ADDRESS				25a. REC'D BY REGISTRAR <i>MAY 15 1967</i>			
								25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			



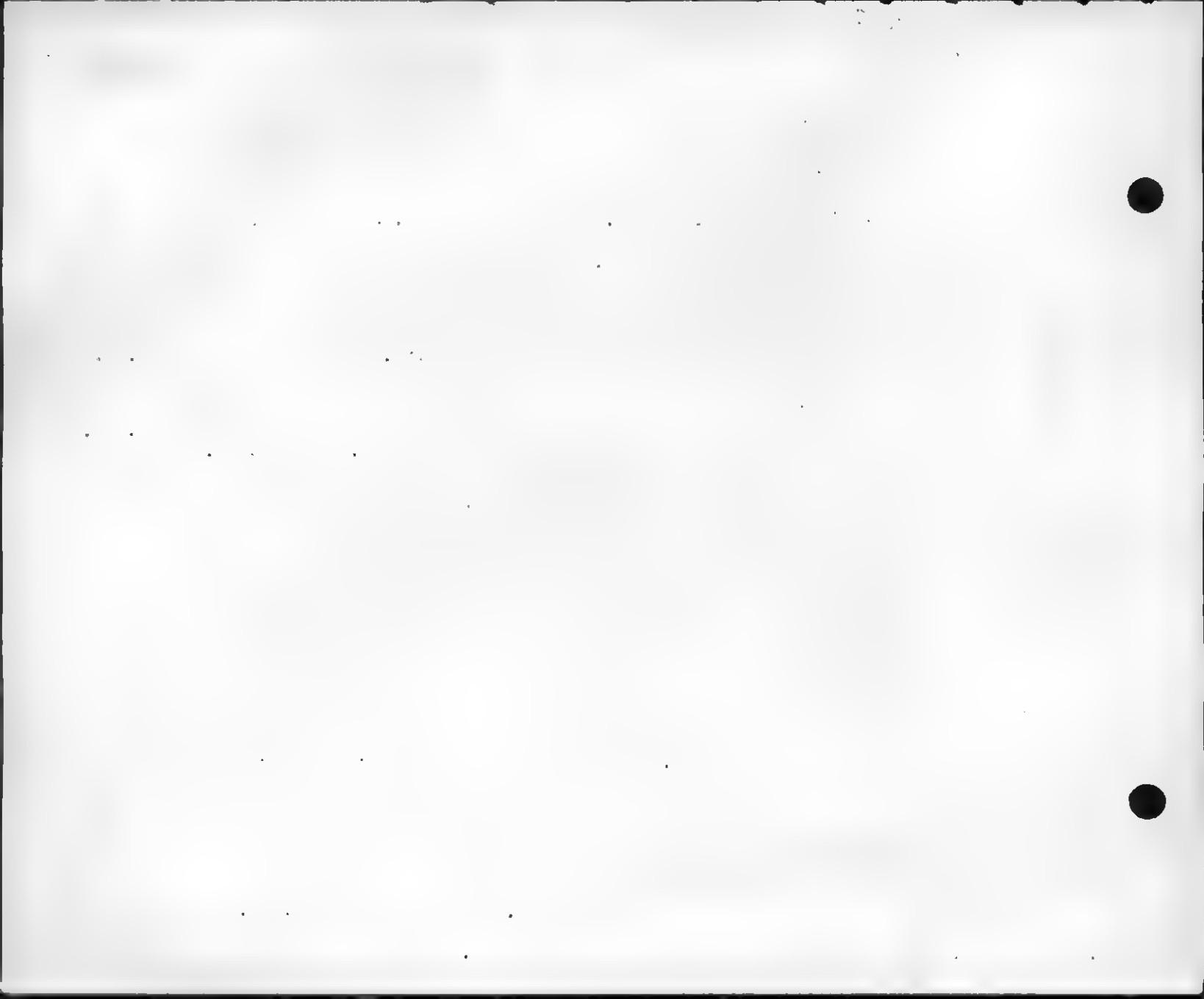
1
TD PHYSICIAN ATTENDING PHYSICIAN FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

\$1.30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoctinville		c. LENGTH OF STAY IN MD 1 week	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House In The Pine, Fusing Ave.		e. STREET ADDRESS 307 S. Augusta Ave.	
3. NAME OF DECEASED (Type or print) Elmira		First E	Middle M.
		Last Travers	4. DATE OF DEATH May 26, 1967
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.	
13. FATHER'S NAME George Aaron		14. MOTHER'S MAIDEN NAME Amelia Kriel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Margaret G. Banks 307 S. Augusta Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		DUE TO Atherosclerotic CV Disease	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/21		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) 307 S. Augusta Ave.
21. I certify that (I) (this hospital) attended the deceased from 4/1 , 19 58 , to 5-26 , 19 67 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 5-26 , 19 67 , and that death occurred at 2:20 PM , from the causes and on the date stated above.		22b. DATE SIGNED 5/28/67	
22a. SIGNATURE J. T. Schwab		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS 3512 Frederick Ave., Balt. Md.	M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave., Balt. Md.		23b. DATE THEREOF May 29, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cem.
		23d. LOCATION (City, town or county) Baltimore, Md.	(State)
		25a. REC'D BY REGISTRAR MAY 31 1967	25b. REGISTRAR'S SIGNATURE Glenda Judge
		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36442

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN b 		c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) 		b. COUNTY Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4314 Barrington Ave.				d. STREET ADDRESS 4314 Barrington Rd. 21229				
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Jay H. Treiber		First	Middle	Last	4. DATE OF DEATH May 21 1967	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/99	9. AGE (In years lost birthday) 67 yrs	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 7	Hours 0
10. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician - Ret.		10b. KIND OF BUSINESS OR INDUSTRY Western Union		11. BIRTHPLACE (County & State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Herbert Treiber				14. MOTHER'S MAIDEN NAME Elizabeth Sheely				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215-03-7490		17. INFORMANT Mrs. Helen I. Treiber		Address 21229 4314 Barrington Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema INTERVAL BETWEEN DUE TO 3 hours Conditions, if any, which gave rise to immediate cause (a) (b) Pulmonary embolism stating the underlying cause (c) A. S. C. V. disease ? DUE TO last								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore (County) Maryland (State)		
21. I certify that (I) (This hospital) attended the deceased from March 1962 to May 21, 1967 , that (I) last saw the deceased alive on May 20, 1967 , and that death occurred at C.A.M. from causes and on the date stated above.								
22a. SIGNATURE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5/22/67								
22c. PHYSICIAN'S NAME (Type) D. C. MacLaughlin		22d. ADDRESS 303 N. Rolling Rd.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67		23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Cemetery		23d. LOCATION (City or Town) Baltimore, Maryland (County) Maryland (State)		
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR DATE MAY 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville						c. LENGTH OF STAY IN 1D 32yr10mth3dys											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) WILLIAM H KERR						4. DATE OF DEATH Last TURNER Month MAY Day 21 Year 1967											
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 28, 1909		9. AGE (in years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer						10b. KIND OF BUSINESS OR INDUSTRY factory						11. BIRTHPLACE (County & State, or foreign country) Maryland					
13. FATHER'S NAME ? Koester						14. MOTHER'S MAIDEN NAME Kate Morgan						12. CITIZEN OF WHAT COUNTRY? U. S.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. None						17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM INTERVAL BETWEEN ONSET AND DEATH hours																	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) LATE COMPLICATION FOLLOWING SURGERY (c) days																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State) 								
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 19 , 19 67 , to MAY 21 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 21 19 67 , and that death occurred at SPRING GROVE ST HOSP M, from the causes and on the date stated above.																	
22a. SIGNATURE George A Ridin						22b. DATE SIGNED 5-21-67											
22c. PHYSICIAN'S NAME (Type) George A Ridin						22d. ADDRESS SPRING GROVE ST HOSP											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/24/67.			23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery			23d. LOCATION (City, town or county) Baltimore, Md. (State) 								
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR DATE MAY 24 1967						25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												06433	
1. PLACE OF DEATH a. COUNTY BALTO						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX			c. LENGTH OF STAY 1b ESSEX			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX			d. STREET ADDRESS 528 FRANKLYN AVE			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hospital Name, Balto													
3. NAME OF DECEASED (Type or print)		528 FRANKLYN AVE		Middle age		Lost Thl		4. DATE OF DEATH MAY 29 1967		Month MAY		Doy 29	Year 1967
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH MAY 30 1893	9. AGE (in years last birthday) 73 yrs	FUNDER 1 YEAR Months 1	FUNDER 1 YEAR Days 0	FUNDER 1 YEAR Hours 0	FUNDER 1 YEAR Min 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARBER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME ADAM UHL						14. MOTHER'S MAIDEN NAME MARY BOHL							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK			16. SOCIAL SECURITY NO			17. INFORMANT LILLIAN UHL			Address ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTO.		'County) MD.		(State) MD.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22. DATE SIGNED 5/29/67	
ACTUAL SIGNATURE Theo S. Patterson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) BALTO, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/1/67		23c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART		23d. LOCATION (City or Town) BALTO, MD		(Co. City) MD.		(State) MD.			
24. FUNERAL DIRECTOR JG CONNELLY		ADDRESS 300 MACLE		25a. REG'D BY REG STRAP JUN 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							
VR ATSMC 6M 1.67													



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1
06445
16434

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page A / by the hospital or physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH

a. COUNTY

Baltimore

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Owings Mills

c. LENGTH OF STAY IN IB

MARYLAND
49 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Timber Grove Road

3. NAME OF
DECEASED
(Type or print)

First

Middle

Lucy

Lee

Last

4. DATE
OF
DEATHMonth
MayDay
1, 1967

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

July 21, 1880

9. AGE (in years
last birthday)

77 yrs.

10. IF UNDER 1 YEAR

Months
DaysHours
Min.11. IS RESIDENCE
ON A FARM?
YES NO 10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Madison Co., Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carpenter

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) If yes give war or date of service

No

16. SOCIAL SECURITY NO. 17 INFORMANT

217-118-1993 Mrs. Evelyn A. Ebaush, Westminster, Md.

Address Penna. Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Nemias

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Arterio clausis CV. Disease

INTERVAL BETWEEN
ONSET AND DEATH

24 hrs.

years

19. WAS AUTOPSY PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 49 While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

20g. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20h. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21. I certify that (I) (this hospital) attended the deceased from April 28, 1967, to May 1, 1967, that (I) (we) last
saw the deceased alive on April 30, 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Martin E. Strobel

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Martin F. Strobel

22d. ADDRESS

Reisterstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

May 4, 1967

23c. NAME OF CEMETERY OR CREMATORIUM

All Saints Cemetery

23d. LOCATION (City, town or county)

Reisterstown, Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

H. J. Eckhardt

ADDRESS

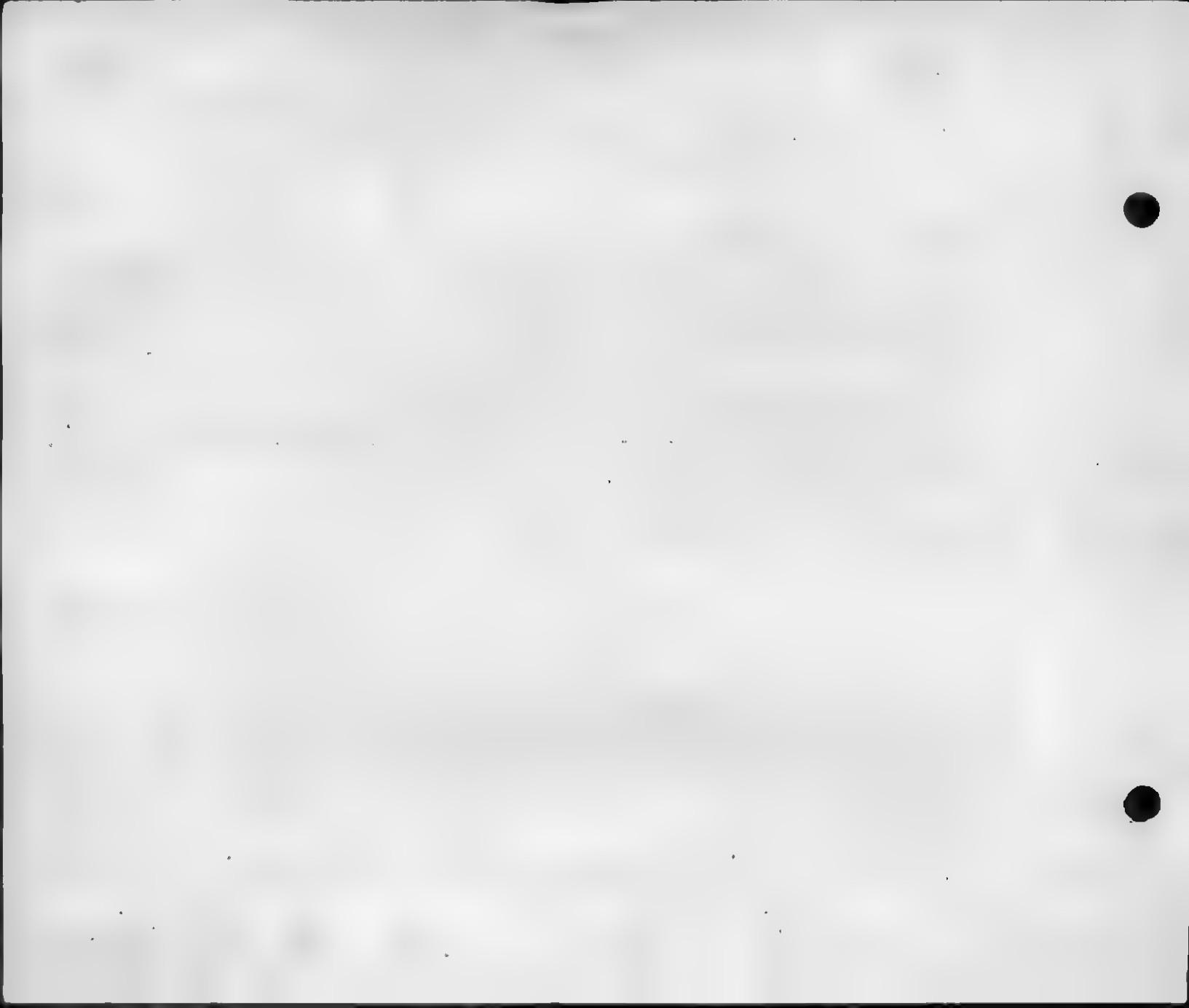
Owings Mills, Md.

25a. REC'D BY REGISTRAR

MAY 4 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7
06446

CERTIFICATE OF DEATH

7
06435

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 through 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			d. STREET ADDRESS 2833 Frederick Ave. 21223			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House In The Pines															
3. NAME OF DECEASED (Type or print) First HENRY			Middle E.			4. DATE OF DEATH Lost SR Month May			Month Day 8 Year 1967						
5. SEX MALE			6. COLOR OR RACE WHITE			7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3/14/88			9. AGE (In years last birthday) 79 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman - retired			10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME John H. Velten			14. MOTHER'S MAIDEN NAME Wilamena Lentz						Address						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE FAILURE 1810 DUE TO BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH			
									(b) DUE TO CHRONIC URINARY TRACT INFECTION (c) CARCINOMA URINARY BLADDER						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-11 , 19 67 , to 5-8 , 19 67 , that (I) (we) last saw the deceased alive on 5-8 19 67 , and that death occurred at 11:00 PM , from causes and on the date stated above.			22a. SIGNATURE Domingo C. Sorongon			22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) DOMINGO C. SORONGON MD						22d. ADDRESS 3915 HOLLINS FERRY RD, BALTIMORE, MD. 21227									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/12/67			23c. NAME OF CEMETERY OR CREMATORIAL Western Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland						
24. FUNERAL DIRECTOR Howard H. Hubbard			ADDRESS 4107 Wilkens Ave. 21229			25a. REC'D BY REGISTRAR MAY 10 1967			25b. REGISTRAR'S SIGNATURE Charles Judge						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

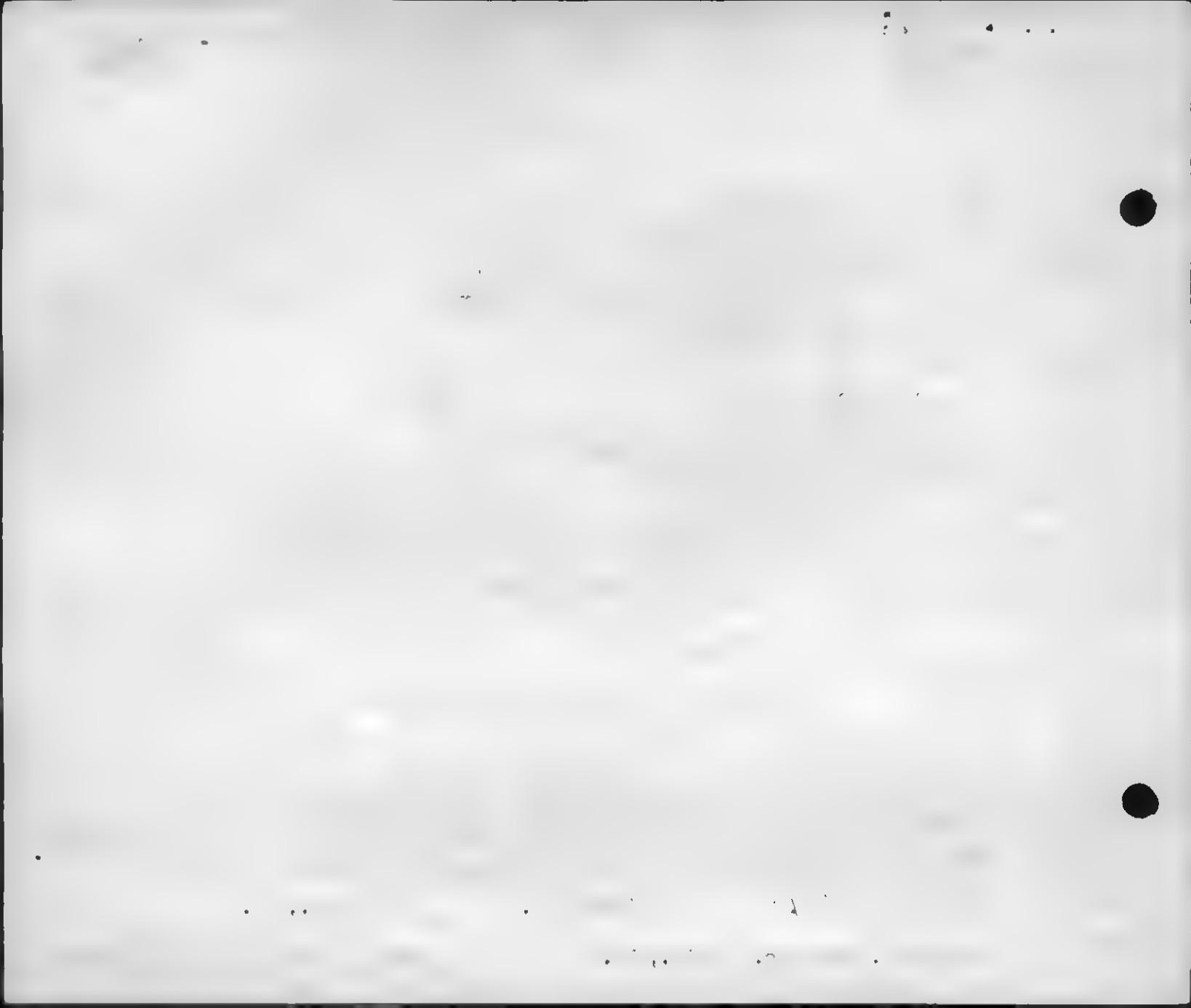
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

£ 21

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence where admit on)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. STATE Md.	
c. LENGTH OF STAY IN 1b				b. COUNTY Balto.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
4208 Silver Spring Rd				Balto Md.	
e. NAME OF DECEASED (Type or print)		First	Middle	d. STREET ADDRESS	
James Holden Vettes				4208 Silver Spring Rd	
3. SEX		6. COLOR OR RACE		4. DATE OF DEATH	
M		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		Month May	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Day 28 Year 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years, less birthday) 67 yrs	
Gardener (Retired 7-8 yrs)				11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
John Vettes		Olive Payne			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank and date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		719-01-9409		Margaret Vettes Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Coronary Artery Occlusion		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		Coronary Artery Disease			
IMMEDIATE CAUSE (a)		Atherosclerotic Cardiovascular Disease			
DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.		(b)			
DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>F.T. KASIK JR.</i> EXAMINER'S NAME (Type)					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 9005 Hartford Rd. DATE SIGNED 5/31/67					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/67		22d. LOCATION (City, town, or country) Balt., Md. (State)	
22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cem.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Leonard J. Ruck Inc., Balt., Md. Charles Judge DATE MAY 31 1967			
23. FUNERAL DIRECTOR		ADDRESS			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

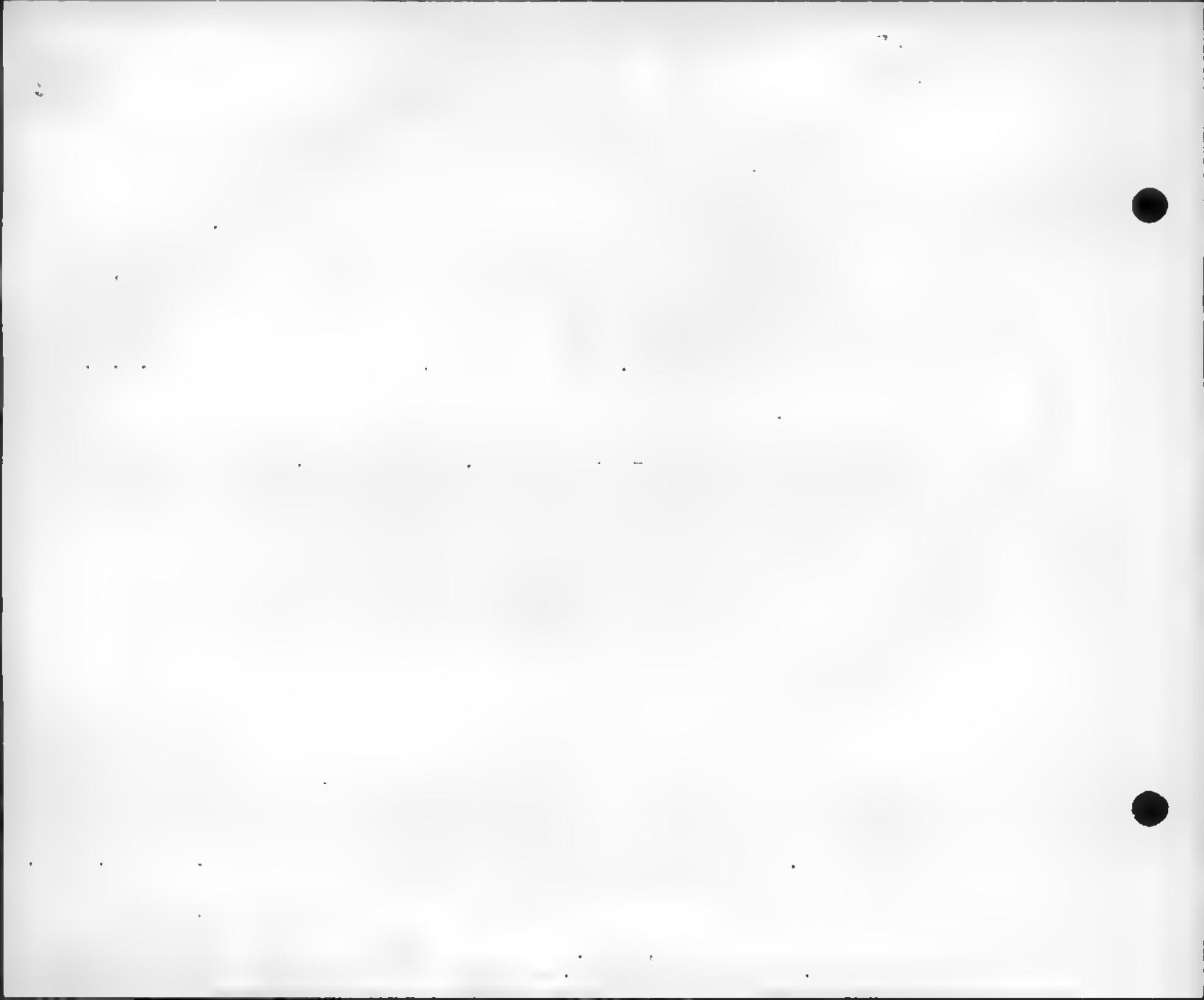
36448

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-trou's permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryla d	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie		c. LENGTH OF STAY IN 1b Anneslie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 608 Windwood Rd.		e. STREET ADDRESS 608 Windwood Rd.	
3. NAME OF DECEASED (Type or print) Leonette Hogan Voelker		First	Middle
4. SEX Female	5. COLOR OR RACE White	6. MARRIED WIDOWED Divorced	7. NEVER MARRIED Divorced
8. DATE OF BIRTH April 11, 1903	9. AGE (In years last birthday) 64 yrs	10. DATE OF DEATH May 10, 1967	11. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personnel Officer	10b. KIND OF BUSINESS OR INDUSTRY Balto. Life Ins. Co.	11. BIRTHPLACE (County & State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James A. Hogan		14. MOTHER'S MAIDEN NAME Cecelia Hoffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO 214-18-9185	17. INFORMANT Mrs. Patricia L. Peroutka
		Address Sum	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Metastatic carcinoma (pancreatic?)</i> 18 mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 .		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore		(County) (State) Maryland	
21. I certify that (I) (This hospital) attended the deceased from December, 1962 to May 10, 1967 , that (I) (we) last saw the deceased alive on May 7, 1967 , and that death occurred at 8 P.M. from causes and on the date stated above			
22a. SIGNATURE <i>Carlton L. Sexton</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED May 11, 1967
22c. PHYSICIAN'S NAME (Type) Dr. Carlton Sexton		22d. ADDRESS 819 Park Ave. Balt., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-12-67		23b. DATE THEREOF 5-12-67	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood
23d. LOCATION (City or Town) Baltimore, Maryland		(County) (State)	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Baltimore, Md. 21212	25a. REC'D BY REGISTRAR DATE MAY 12 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

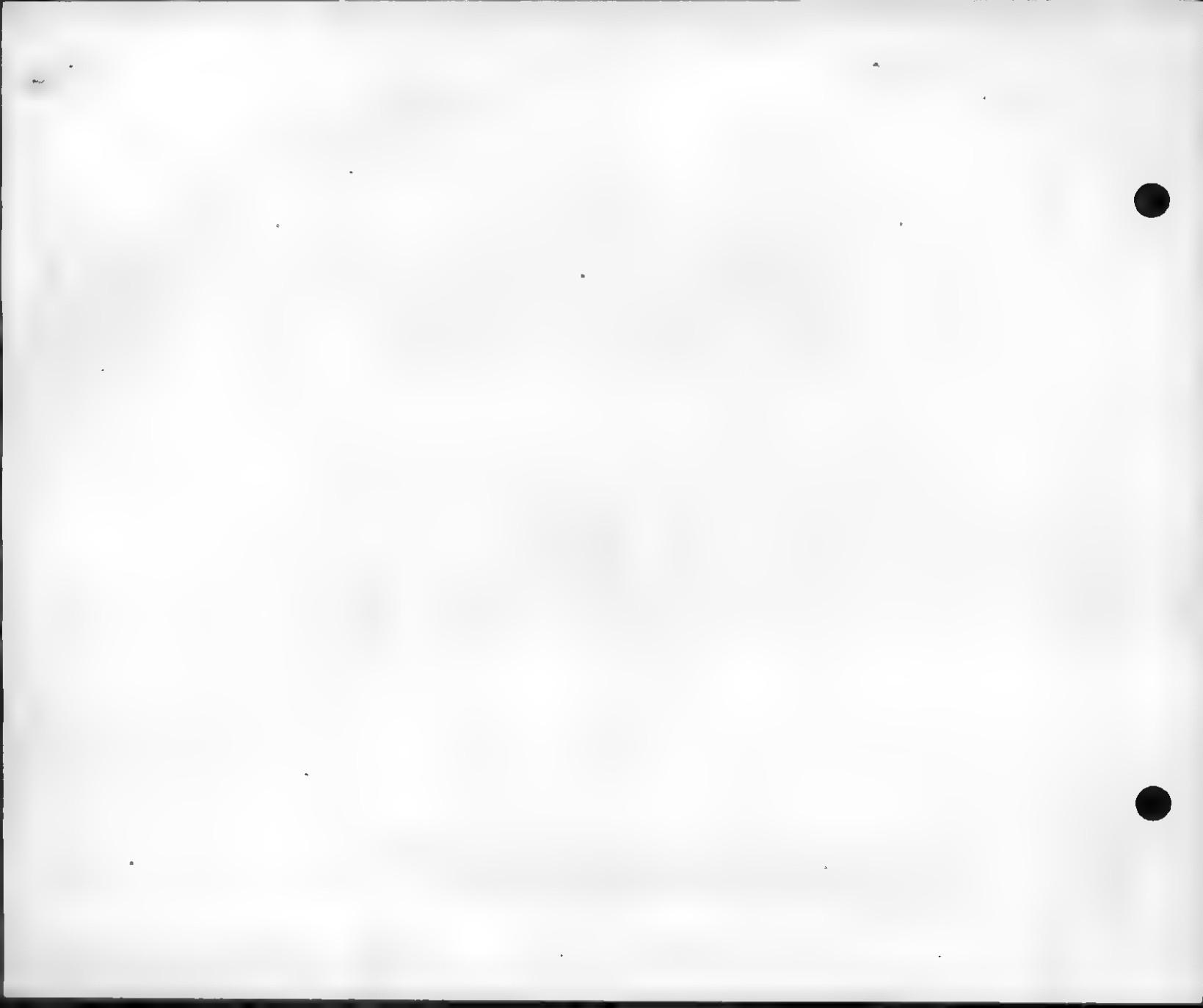
CERTIFICATE OF DEATH

DC 428

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 M													
36443													
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 7 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 216 Eastspring Rd. 21093				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Louis	Middle J.	Last Voluz	4. DATE OF DEATH	Month May	Day 6	Year # 5 1967	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/22/82		9. AGE (In years last birthday) yrs. 85								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Waiter		11. BIRTHPLACE (County & State, or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Voluz				14. MOTHER'S MAIDEN NAME Angeline Gaillard									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 064 03 7764		17. INFORMANT Hospital Records		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pyonephrosis <small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</small> (b) Prostatic Hypertrophy <small>DUE TO</small> <small>lost.</small> (c)								INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Renal Cell Carcinoma								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) - (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 27, 1967, to May 6, 1967, that (I) (we) lost the deceased alive on May 6, 1967, and that death occurred at 10:20 P.M. from causes and on the date stated above.													
22a. SIGNATURE Dr. Reynaldo Orjuela-Gomez		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204											
23a. BURIAL, CREMATION, REMOVAL (Specify Burial)		23b. DATE THEREOF 5-11-67		23c. NAME OF CEMETERY OR CREMATORIAL Mt St. Marys		23d. LOCATION (City or Town) Flushing N.Y. (County) (State)							
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Md.				ADDRESS		25a. REC'D. BY REGISTRAR MAY 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06450

CERTIFICATE OF DEATH

06439

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanhamsville</i>		b. COUNTY	
c. LENGTH OF STAY IN TB <i>6 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>House In the Pines</i>		d. STREET ADDRESS <i>2153 Sidney Ave</i>	
e. NAME OF DECEASED (Type or print) <i>Edward E. Wahl</i>		e. DATE OF DEATH Month Day Year <i>5 / 9 / 1967</i>	
f. SEX <i>Male</i>		g. COLOR OR RACE <i>White</i>	
h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		i. DATE OF BIRTH Year <i>3/21/1910</i>	
j. WIDOWED <input type="checkbox"/>		k. DIVORCED <input type="checkbox"/>	
l. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Glass Cutter</i>		m. 11. KIND OF BUSINESS OR INDUSTRY <i>Glass Co.</i>	
n. 12. FATHER'S NAME <i>Ernest E. Wahl</i>		o. 13. MOTHER'S MAIDEN NAME <i>Lillian M. Gontium</i>	
p. 14. MOTHER'S MAIDEN NAME <i>Mrs Francis Coleman Wahl</i>		q. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Address (Yes, no, or unknown) <i>No</i>	
r. 16. SOCIAL SECURITY NO. <i>123-45-6789</i>		s. 17. INFORMANT <i>above</i>	
t. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		u. INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
v. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Ca of Prostate</i>		w. 23. WAS AUTOPSY PERFORMED? <i>NO</i>	
x. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Emphysema Ca of Lung</i>		y. 24. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>	
z. 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		aa. 21. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>from causes and on the date stated above.</i>	
bb. 22. SIGNATURE <i>Wilmer K. Gallagher</i>		cc. 23. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher, M.D.</i>	
dd. 24. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <i>Burial 5/11/67</i>		ee. 25. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Eaton Haven Cemetery</i>	
ff. 26. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Cowan & Son Inc.</i>		gg. 27. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
hh. 28. REC'D BY REGISTRAR DATE MAY 12 1967		ii. 29. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

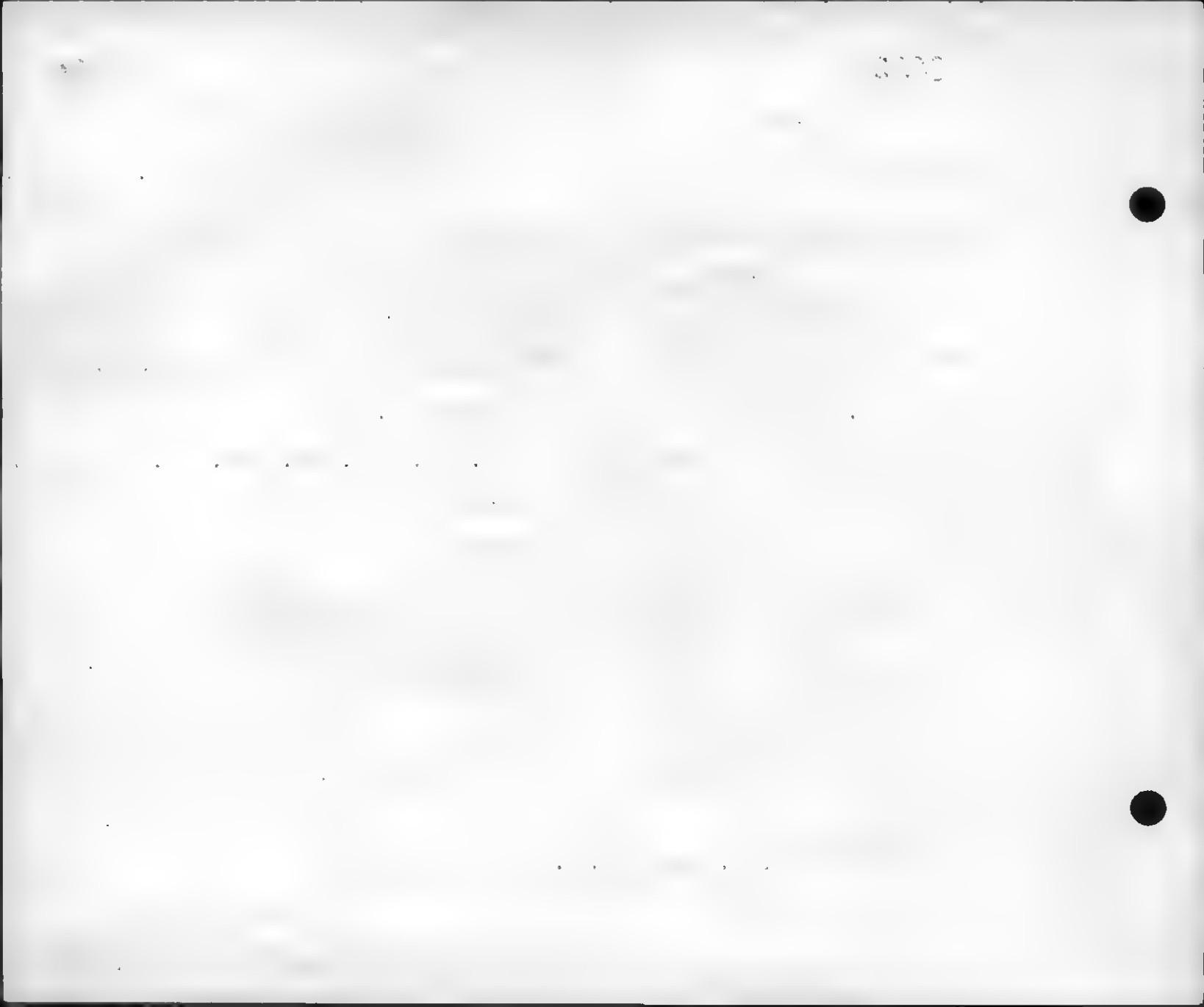
DEATH

36451

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 16 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3 NAME OF DECEASED (Type or print) THOMAS ISAAC WALLACE		f. STREET ADDRESS 721 NORTH FREMONT AVENUE	
4 DATE OF DEATH MAY 22, 1967	Month Day Year	g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 NEVER MARRIED <input type="checkbox"/>
9. DATE OF BIRTH JUNE 18, 1893		9. AGE (in years last birthday) 73 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISPLAYER		11. BIRTHPLACE (County & State, or foreign country) CALVERT COUNTY, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM H. WALLACE	
14. MOTHER'S MAIDEN NAME AMELIA E. COOKE		15. SOCIAL SECURITY NO. 212 09 90 56	
16. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		19. INTERVAL BETWEEN ONSET AND DEATH RECENT	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from May 20, 1967 , to May 22, 1967 , that (I) (we) last saw the deceased alive on MAY 22, 1967 , and that death occurred 12:45 a.m. from causes and on the date stated above			
22a. SIGNATURE <i>Howard C. Kramer, M.D.</i>		22b. DATE SIGNED 5/22/67	
22c. PHYSICIAN'S NAME (Type) HOWARD C. KRAMER, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-24-67	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL
24. FUNERAL DIRECTOR		23d. LOCATION (City or Town) BALTIMORE, MARYLAND	
ADDRESS ELROY O WILSON FUNERAL HOME		23e. RECEIVED BY REGISTRAR MAY 23 1967	23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
1000 BRANTLEY AVE. BALTIMORE, MD.			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06452

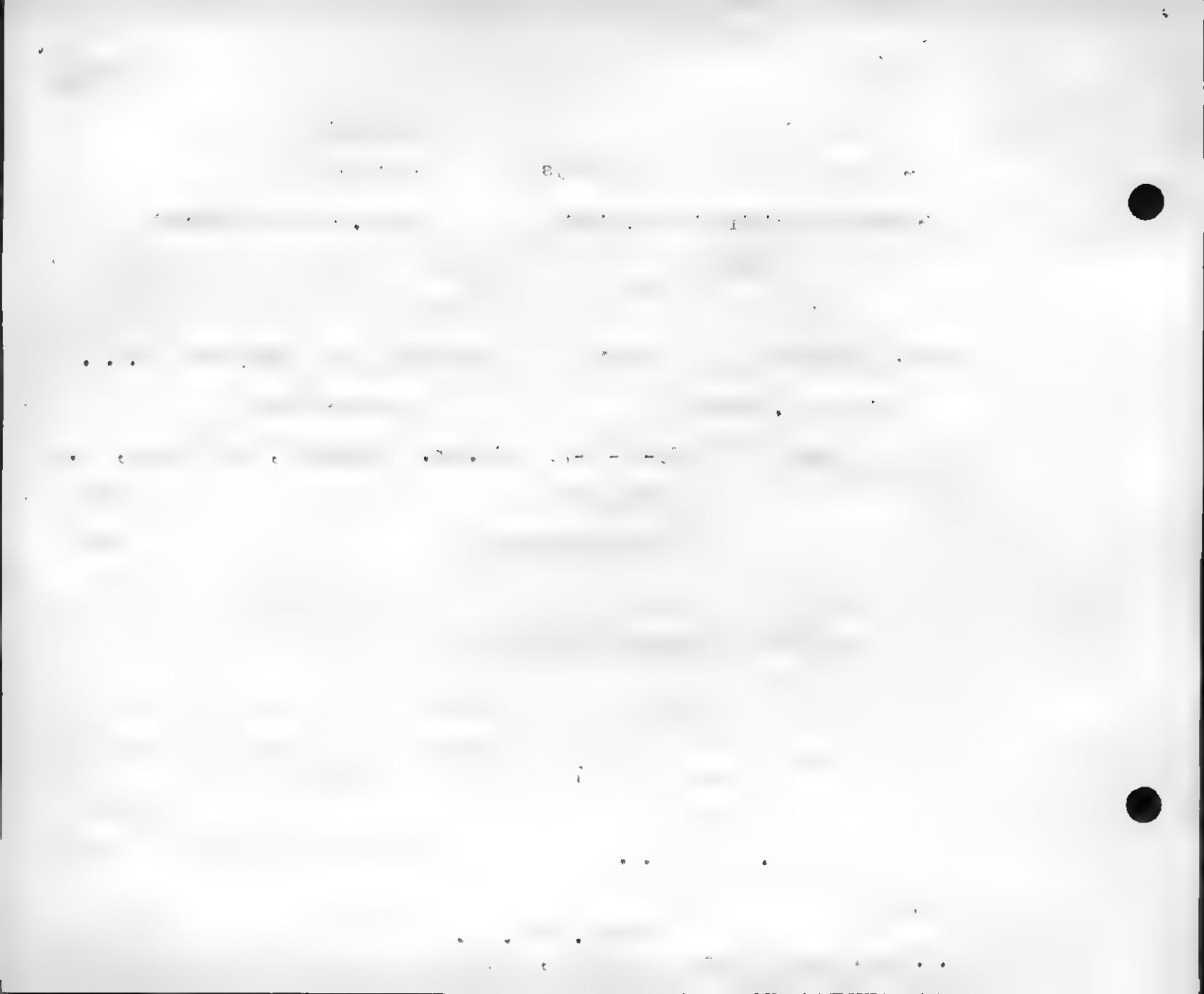
CERTIFICATE OF DEATH

06452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event where the funeral director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 129 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 2925 E. Baltimore Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle JOHN	Last WALTON	4 DATE OF DEATH Month MAY	Day Year 28 19 67
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/91	9 AGE (in years last birthday) 75 yrs	10 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Nail Helper		10b. KIND OF BUSINESS OR INDUSTRY Steel		11 BIRTHPLACE (County & State, or foreign country) Baltimore County, Maryland	
13. FATHER'S NAME William T. Walton			14. MOTHER'S MAIDEN NAME Florence Fuller		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. 23-09-13711		
17. INFORMANT Clin. Rec., VA Hospital, Fort Howard, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH LESS THAN 10 DAYS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X			YEARS		
(b) DUE TO DIABETES MELLITUS					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
PERIPHERAL VASCULAR INSUFFICIENCY					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from January 19, 1967 , to May 28, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 28, 1967 , and that death occurred at 5:50 AM from causes and on the date stated above					
22a. SIGNATURE <i>John W. Payne</i>		22b. DATE SIGNED 5/28/67			
22c. PHYSICIAN'S NAME (Type) JOHN W. PAYNE, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/67		23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery	
24. FUNERAL DIRECTOR J.A. Moran Funeral Home		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		23e. REGISTRATION NUMBER 3000 E. Balto. St.	
				23f. DATE MAY 31 1967	
				23g. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

36453

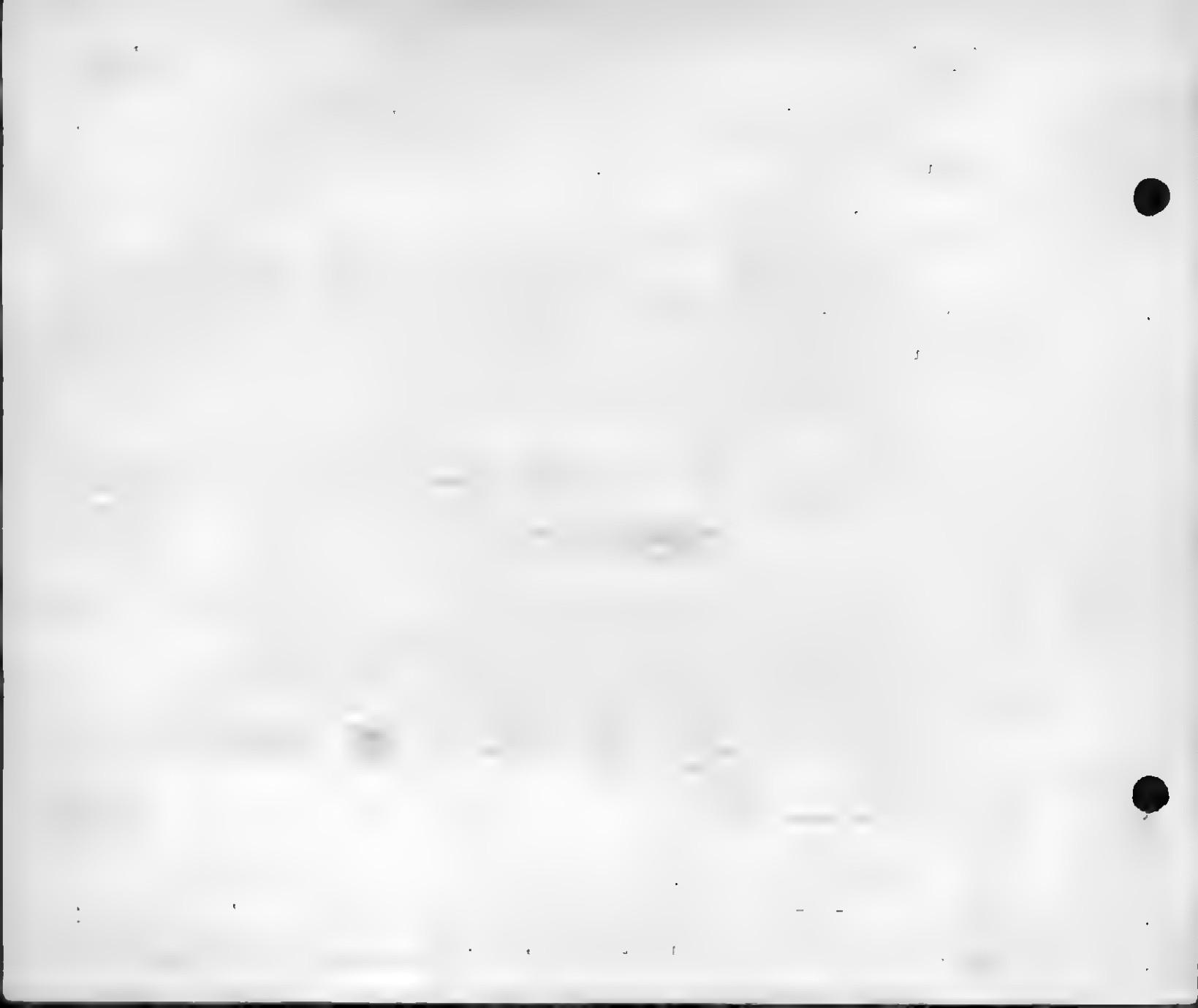
CERTIFICATE OF DEATH

16442

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 31/2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Robb Nursing Home		d. STREET ADDRESS 8310 Liberty Road	
3. NAME OF DECEASED (Type or print) Anna		4. DATE OF DEATH Last Month Day Year 3-1-1872 May 28 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1872	
9. AGE (In years last birthday) 95 yrs.		10. BIRTHPLACE, County & State, or foreign country Waterman Germany	
11. CITIZEN OF WHAT COUNTRY? USA		12. MOTHER'S MAIDEN NAME Unknown	
13. FATHER'S NAME Henry Thune		14. INFORMANT Helen Marsh - 3521 Abbie Place	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis		18. DUE TO (b) Hypertension	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		19. INTERVAL BETWEEN ONSET AND DEATH 3 days 16 years	
20e. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 15, 1967 to May 28, 1967 , that (I) (we) last saw the deceased alive on Mar 24, 1967 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.		22. SIGNATURE Edward Murphy	
22c. PHYSICIAN'S NAME (Type) Edward Murphy		23. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 24. DATE SIGNED 5/29/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Druide Ridge Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. GENERAL DIRECTOR'S SIGNATURE Edward Murphy		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge			
Ellsworth Armacost - 4600 Liberty Hghts, Ave.		MAY 31 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

36454

CERTIFICATE OF DEATH

36443

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Burwood Ct.</i>		d. STREET ADDRESS <i>Burwood Ct.</i>	
3. NAME OF DECEASED (Type or print) <i>James</i>		First <i>James</i>	Middle <i>Griffis</i>
4. DATE OF DEATH <i>May 6, 1967</i>		Last <i>Watkins</i>	Month Day Year <i>May 6, 1967</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 1, 1919</i>		9. AGE (In years, last birthday) <i>48 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>President Top Crafts Inc.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (County & State, or foreign country) <i>Smithville, Va.</i></i>	
11. CITIZEN OF WHAT COUNTRY? <i>USA</i>		12. FATHER'S NAME <i>James R. Watkins</i>	
13. MOTHER'S MAIDEN NAME <i>Mattie Griffis</i>		14. INFORMANT <i>Mrs. Lavinia D. Watkins Lutherville, Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) <i>yes</i>		16. SOCIAL SECURITY NO. <i>217-07-7916</i>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>17CX</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
20a. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>
21 I certify that (I) (this hospital) attended the deceased from..... saw the deceased alive on.....		21b. DATE <i>5/3/67</i>	
22e. SIGNATURE <i>Milton B. Kirsh</i>		22b. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Milton B. Kirsh, M.D.</i>		22d. ADDRESS <i>4000 W. Northern Parkway - Baltimore, Md.</i>	
23e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 9, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Dundridge Cemetery</i>		23d. LOCATION (City, town or county) <i>Pikesville, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Eline & Sons Reisterstown, Md.</i>		25a. REC'D. BY REGISTRAR DATE <i>MAY 9 1967</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

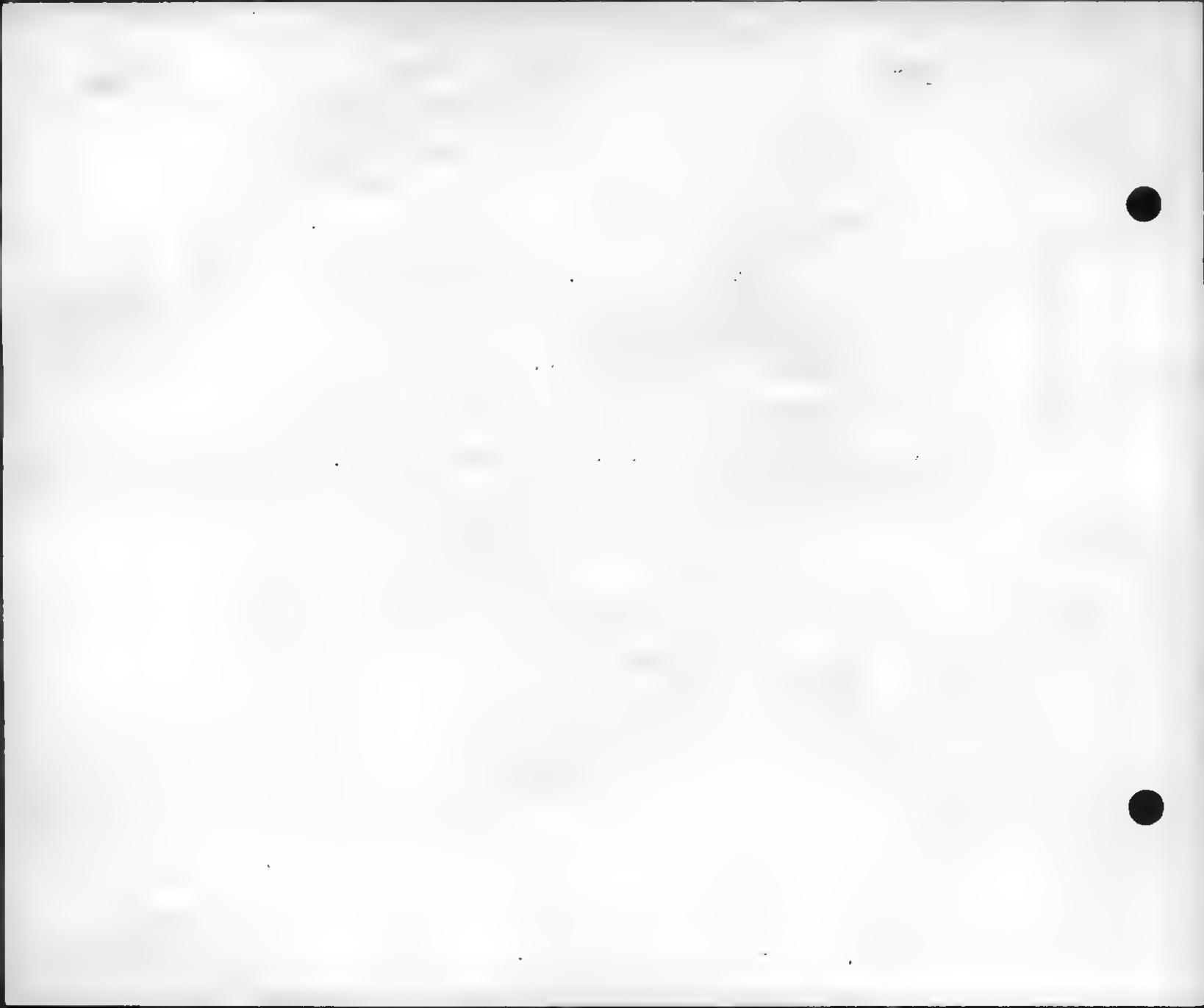
1
2
96455

CERTIFICATE OF DEATH

96444

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2915 Ohio Ave.		e. STREET ADDRESS 2915 Ohio Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 21227		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George W. Westphal		4. DATE OF DEATH May 20 1967	Month Doy Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/15/05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Cutter		9. AGE (In years lost birthday) 61 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Eickeberg Co.		10. IF UNDER 1 YEAR Months Days Hours Min	
13. FATHER'S NAME Charles Westphal		11. BIRTHPLACE (County & State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		12. CITIZEN OF WHAT COUNTRY? USA	
(If yes give war or dates of service) WW II		16. SOCIAL SECURITY NO 214-03-2055	17. INFORMANT Mr. Wilbur L. Polk
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4/21/11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <i>Ac. Coronary occlusion</i> <i>A.S.C.V.D.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10, 30 , 19 67 to 5-17-67 , 19 67 , and that (I) (we) last saw the deceased alive on 5-17-67 and that death occurred at 6 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Justin Kudirka</i>		22b. DATE SIGNED 5-22-67	
22c. PHYSICIAN'S NAME (Type) Justin Kudirka		22d. ADDRESS 2151 Wilkens Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/24/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard	25a. RECD BY REGISTRAR MAY 23 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. Hubbard</i>	
VR A15 (4) 25M 1/67			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

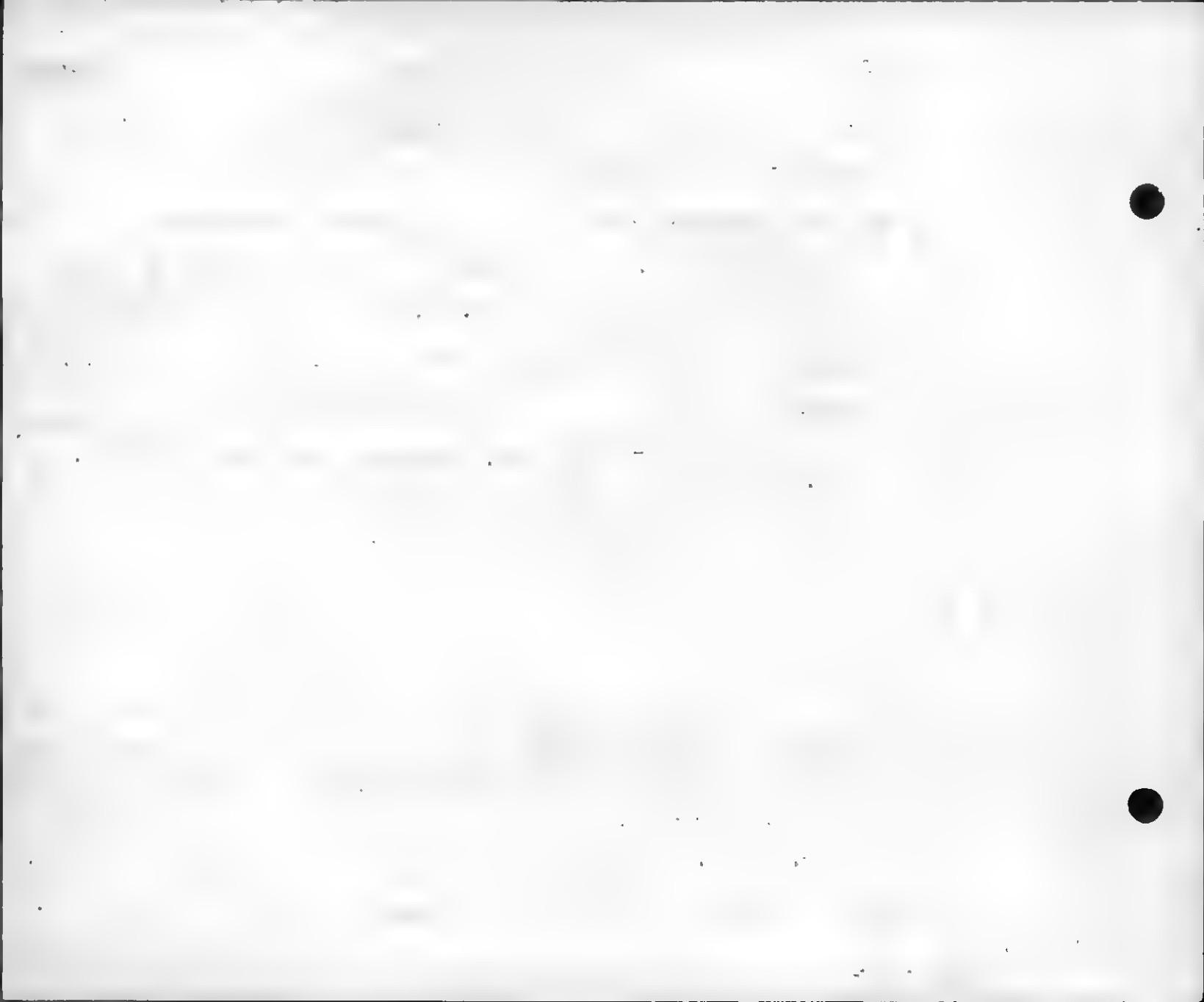
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20 M 1/68

96456

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb 45yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 337 Rte 2 Deer Park Road			d. STREET ADDRESS Box 337 Rt 2 Deer Park Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Cecelia	Middle T.	Last White	4. DATE OF DEATH Month May Day 18 Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 24, 1888	9. AGE (In years, months, days) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Florist		10b. KIND OF BUSINESS OR INDUSTRY Florist Business		11. BIRTHPLACE (County & State, or foreign country) Chicago, ILL.	
13. FATHER'S NAME (unknown)			14. MOTHER'S MAIDEN NAME Hattie Whitley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 217-32-9782		17. INFORMANT Mrs. Frieda Meginnis Box 337 Rt 2 Deer Pk Rd. Owings Mills Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure INTERVAL BETWEEN ONSET AND DEATH 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) metastatic carcinoma DUE TO (c) Carcinoma rectum					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 1962 to May 18, 1967 , that (1) (we) last saw the deceased alive on May 18, 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above.					
22a. SIGNATURE John Darrell					
22c. PHYSICIAN'S NAME (Type) Dr. John J. Darrell		22b. DATE SIGNED 5-20-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/67		23c. NAME OF CEMETERY OR CREMATORIUM Druide Ridge Cemetery	
24. FUNERAL DIRECTOR Soring Byars		ADDRESS 8728 Liberty Rd Randallstown Md		25a. REC'D BY REGISTRAR DATE MAY 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36457

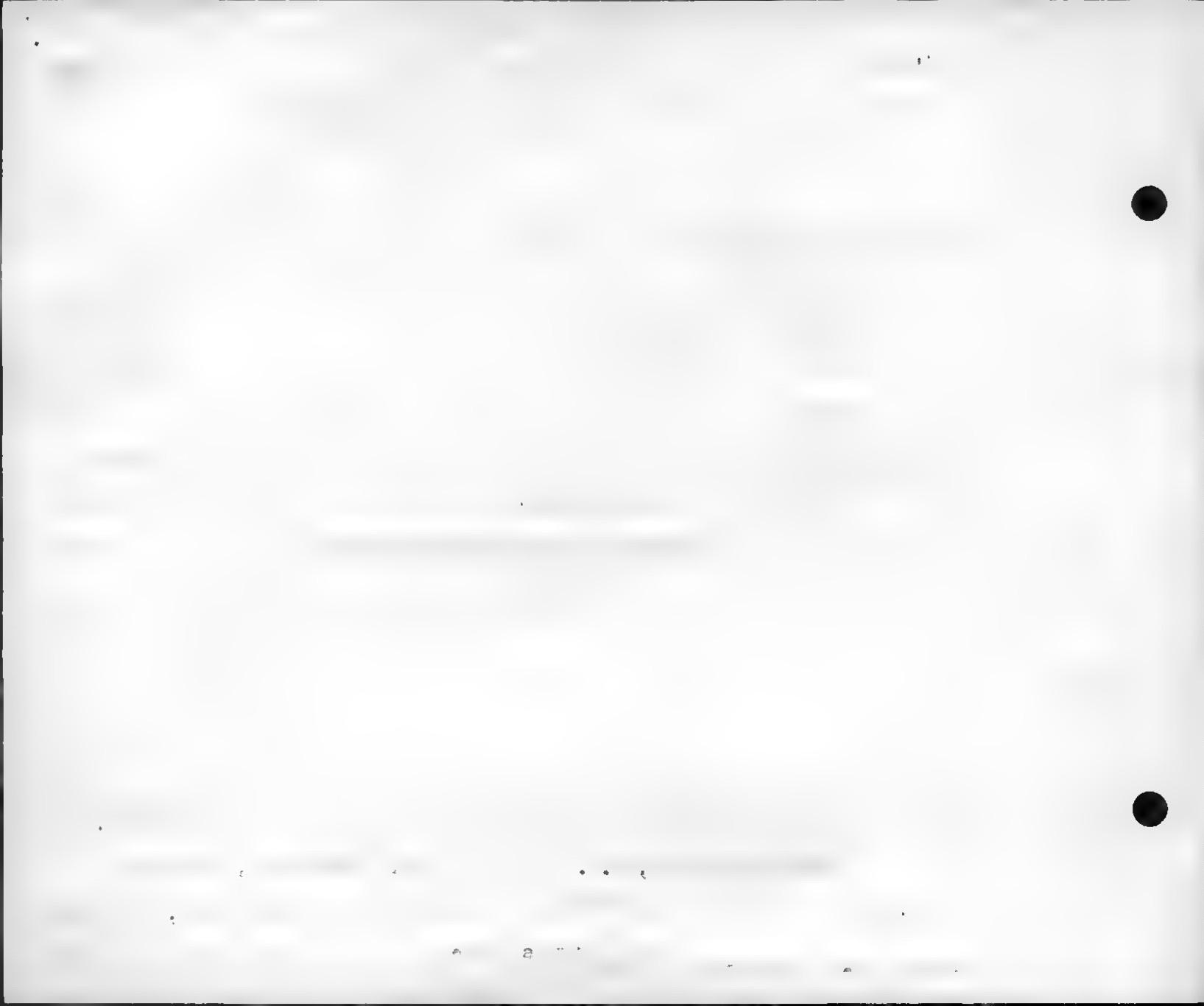
CERTIFICATE OF DEATH

36457

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	c. LENGTH OF STAY IN 1b 15 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 930 BROOKS LANE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VERNON	Middle ANTHONY	4. DATE OF DEATH Month WHITTINGTON MAY 27 1967
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 27, 1920
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) KITCHEN HELPER		10b. KIND OF BUSINESS OR INDUSTRY SUN PAPERS	
11. BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES WHITTINGTON		14. MOTHER'S MAIDEN NAME MARY WHITTINGTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-II		16. SOCIAL SECURITY NO. 216 12 23 54	
17. INFORMANT CLIN. REC., VAH, FT. HOWARD, MARYLAND		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4344		INTERVAL BETWEEN ONSET AND DEATH YEARS	
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.		CARDIAC FAILURE	
DUE TO (c)		CARDIAC DISEASE, UNKNOWN ETIOLOGY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, FORT HOWARD, MARYLAND
20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from May 12 1967 to May 27, 1967 , that (X) (we) last saw the deceased alive on May 27, 1967 , and that death occurred 12:00P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>John Walter Payne</i>		22b. DATE SIGNED 5/28/67	
22c. PHYSICIAN'S NAME (Type) JOHN WALTER PAYNE, M.D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-67	
23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCAT ON (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Morton & Dyett Funeral Home Baltimore, Maryland		25a. ADDRESS 1701 Laurens Street	
		25b. REC'D BY REGISTRAR DATE MAY 31 1967	
		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **Balto. Co.** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Upperco**
c. LENGTH OF STAY IN TB
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Dover Rd.**

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE **Md.** b. COUNTY **Balto. Co.**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Upperco**
d. STREET ADDRESS **Dover Rd.**

3. NAME OF DECEASED (Type or print) **Herman B. Wickline**

4. DATE OF DEATH **May 18, 1967**

5. SEX **Male** **6. COLOR OR RACE** **White** **7. MARRIED** **NEVER MARRIED** **8. DATE OF BIRTH** **April 29, 1906**
WIDOWED **DIVORCED**

9. AGE (in years last birthday) **61** yrs. **10. IF UNDER 1 YEAR** **Months** **Days** **11. IF UNDER 24 HRS.** **Hours** **Min.**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Mechanic** **10b. KIND OF BUSINESS OR INDUSTRY** **Garage** **11. BIRTHPLACE (County & State, or foreign country)** **West Va.**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **James W. Wickline** **14. MOTHER'S MAIDEN NAME** **Lenna Dameron**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) **No.** **16. SOCIAL SECURITY NO.** **189-09-6639** **17. INFORMANT** **Mrs. May Wickline** Dover Rd. Upperco, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) **Brachogenic Cancer**
1621 **DUE TO**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. **(b)** **Enphysema**
{ **DUE TO**
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) **19. WAS AUTOPSY PERFORMED?** **YES** **NO**

20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING **OR CONTRIBUTING** **CAUSE OF DEATH** (If either, notify MEDICAL EXAMINER)

20b. TIME OF INJURY **Month, Day, Year** **20d. INJURY OCCURRED** **While at work** **Not While at work** **20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)** **20f. (City or town)** **(County)** **(State)**

Hour a.m. **p.m.** **19**

21. I certify that (I) (this hospital) attended the deceased from **February 1966** **to May 18, 1967**, **that (I) (we) last saw the deceased alive on** **May 17, 1967**, **and that death occurred at** **Upperco**, **from the causes and on the date stated above.**

22a. SIGNATURE **Charles E. Weller** **22b. DATE SIGNED** **5-18-67**

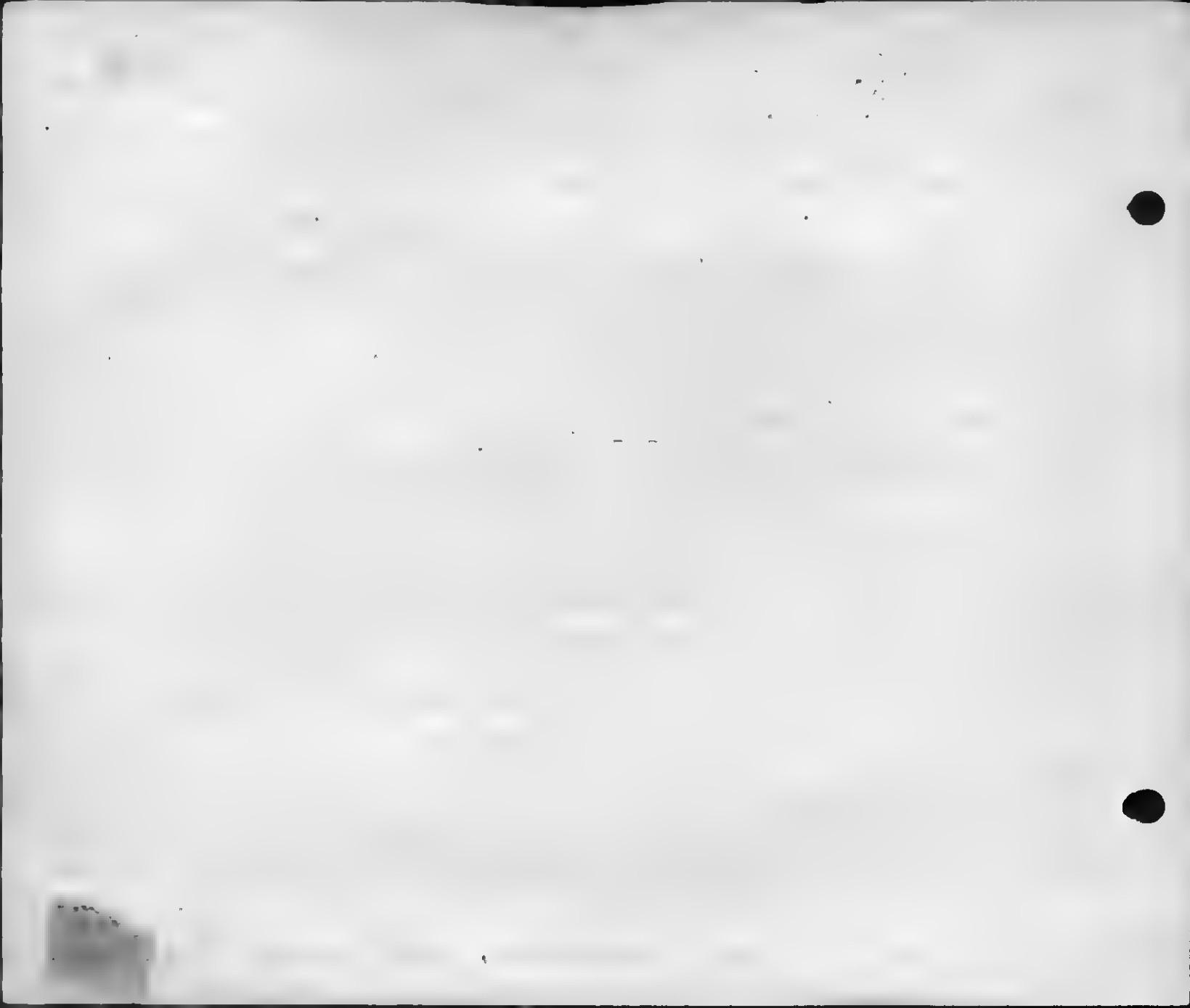
22c. PHYSICIAN'S NAME (Type) **Charles E. Weller**

22d. ADDRESS **11904 Kesterstown Rd Kesterstown Md**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** **23b. DATE THEREOF** **5/21/67** **23c. NAME OF CEMETERY OR CREMATORIUM** **Pleasant Grove Cemetery** **23d. LOCATION (City, town or county)** **Upperco** **(State)** **Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **Tipton - Eline Funeral Home** **Hampstead, Md.** **ADDRESS**

25a. REC'D. BY REGISTRAR **MAY 22 1967** **25b. REGISTRAR'S SIGNATURE** **Charles Judge**



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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36459

CERTIFICATE OF DEATH

J6118

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>maryland</i>		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore - Md. 21230</i>		d. STREET ADDRESS <i>1214 Patapsco Street.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Greater Balt. Medical Center.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>George F. Widmer</i>		First	Middle	Lost	4. DATE OF DEATH <i>May 29 1967</i>	Month	Day	Year	
S SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input type="checkbox"/> <i>Divorced</i>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>3-28-98</i>	9. AGE (In years lost birthday) <i>69 yrs</i>	F UNDER 1 YEAR Months <i>3</i>	F UNDER 1 DAY Hours <i>12</i>	F UNDER 24 HRS Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired pipefitter</i>		10b. KIND OF BUSINESS OR IND. STRY <i>Grinnell Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Buffalo, New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>George Widmer</i>		14. MOTHER'S MAIDEN NAME <i>Burch Gertrude</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>215-09-7802</i>	17. INFORMANT <i>Pt's. Chapt. Lura Jirner-1214Patapco St.</i>			Address <i>1214 Patapco St.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		METASTATIC CB. RECTUM				INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost.</i>		(b)							
DUE TO <i></i>		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>CACHEXIA</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month Day, Year Hour o.m. pm <i>19</i>	20d. INJURY OCCURRED Where at work <input type="checkbox"/> Not at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>				
21. I certify that (I) (this hospital) attended the deceased from <i>5/27 1967</i> to <i>5/29 1967</i> , that (I) (we) last saw the deceased alive on <i>5/29 1967</i> , and that death occurred at <i>440 M.</i> from causes and on the date stated above.									
22a. SIGNATURE <i>Evelyn L. Ramos, M.D.</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22b. DATE SIGNED <i>5/29/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>EVELYN L. RAMOS, M.D.</i>		22d. ADDRESS <i>G.B.M.C. Tolson 4</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>June 1/67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Medicwridge Cemetery</i>		23d. LOCATION (City or Town) <i>Washington Blvd. Md.</i>		(County) <i></i>		(State) <i></i>	
24. FUNERAL DIRECTOR <i>Krause Funeral Home 1215 S. Charles St.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>J. Charles Judge</i>		25b. REG-STRAR'S SIGNATURE			
				DATE <i>MAY 31 1967</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06460

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission) a. STATE Maryland Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b 4yr3mth4dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cyrus		First Williams	Middle Williams
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1892
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years lost birthday) 75 yrs
13. FATHER'S NAME Henry Earl Williams		11. BIRTHPLACE (County & State, or foreign country) South Carolina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO 213-07-6389	17. INFORMANT Records: Spring Grove State Hospital
		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>4-3-21</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>lost</u>		Cardiac failure	
(b) DUE TO		Arteriosclerotic cardiovascular disease	
(c) DUE TO		Arteriosclerosis, generalized and severe	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour: m.p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2-20-63 to May 24, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 1:20 p.m. M, from causes and on the date stated above.		22b. DATE SIGNED 5-24-67	
22c. SIGNATURE Stella Wachslor		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29/67	23c. NAME OF CEMETERY OR CREMATORIUM Mt Calvary Cemetery
24. FUNERAL DIRECTOR Robert E. Williams		ADDRESS 1701-23 Bascom St.	25a. REGISTRATION NUMBER 1907
			25b. REGISTRATION NUMBER judge

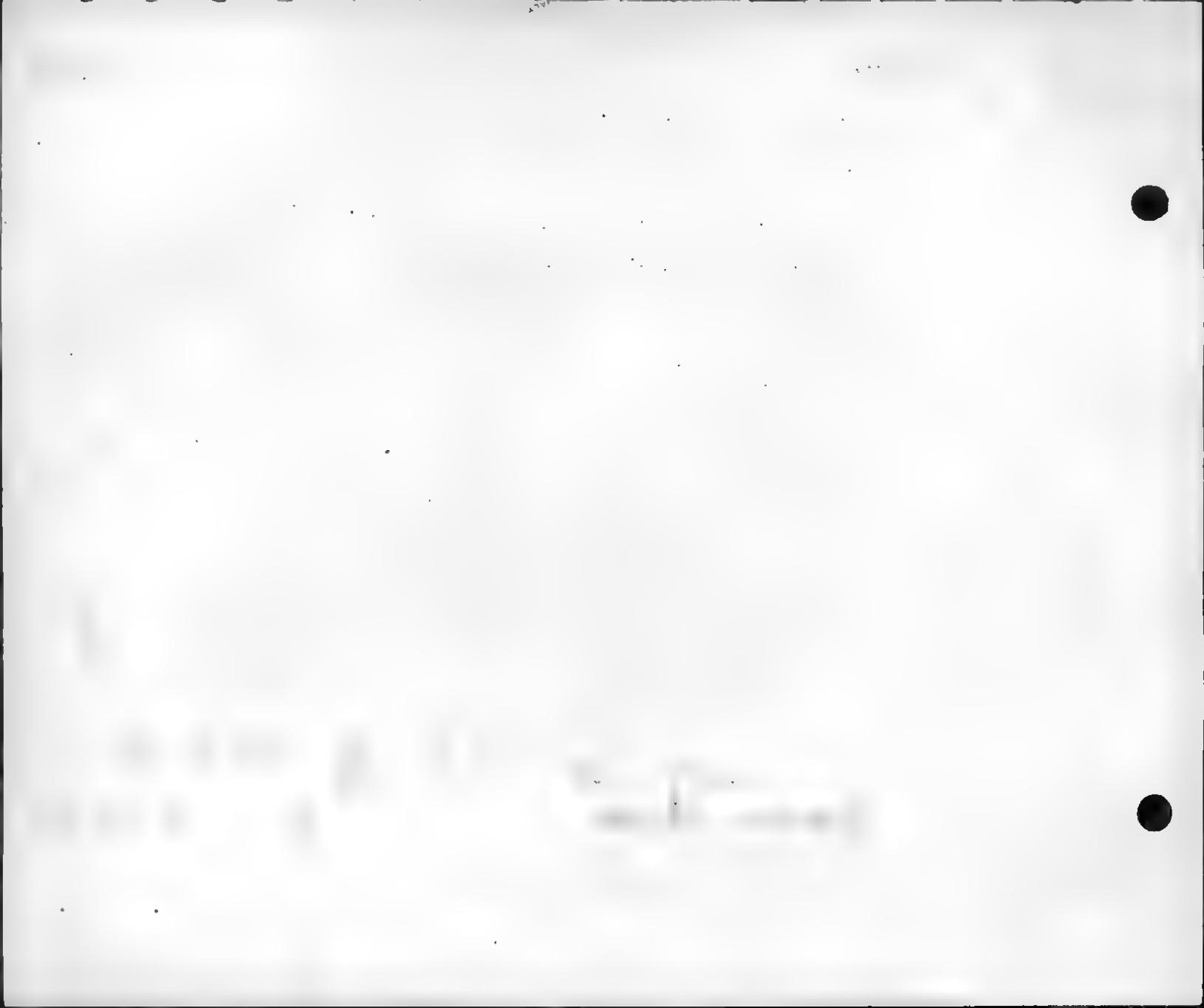


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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #11 & 12 File #6389 5-15-67											
1. PLACE OF DEATH a. COUNTY Baltimore Maryland MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson											
c. LENGTH OF STAY IN 1B 40 yrs.											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER Baltimore Medical Center											
e. STREET ADDRESS 6531 Corkley Road 6											
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED First William		Middle Frederick		Last WISSEL		4. DATE OF DEATH	Month MAY	Day 15	Year 1967		
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR / IF UNDER 24 HRS. Months Days Hours Min.	
						07-03-07		59 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
COTTER OPERATOR		CrownCart & Son Corp.		WNY KNOXVILLE Md.		U.S.A.					
13. FATHER'S NAME William Frederick WISSEL		14. MOTHER'S MAIDEN NAME WIEGAND		15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 213-01-6707		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Wide spread tumor metastases Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma of colon (c)	
										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 13, 1967, to May 15, 1967, that (I) (we) last saw the deceased alive on May 15, 1967, and that death occurred at 12 th AM, from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Smith											
22b. DATE SIGNED 5-15-67											
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-18-1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS (36) Zion Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Co. Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Lassahn Funeral Home 7101 Belair Road MAY 17 1967 Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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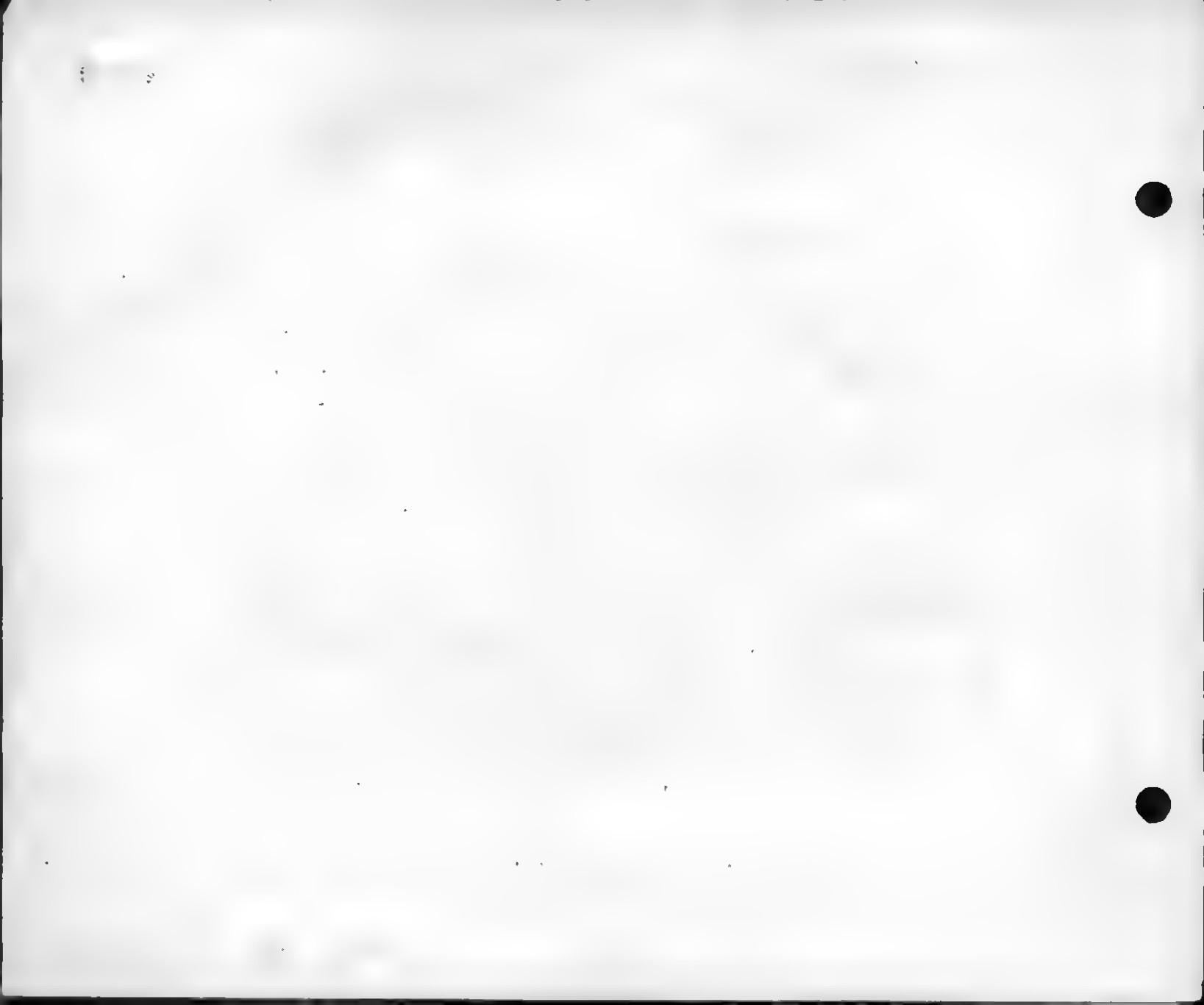
VR A15 (4)
20 M 1/66

96462

CERTIFICATE OF DEATH

16250

1 PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		St. Joseph Hospital		Baltimore 21221	
3. NAME OF DECEASED (Type or print)		First Anna	Middle Marie	Lost Wolf	4 DATE OF DEATH Month May Day 3. Year 19 67
S SEX Female	6 COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1-16-92	9 AGE (In years last birthday) 76 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
13. FATHER'S NAME JOHN SEITZ		14. MOTHER'S MAIDEN NAME MARY BOEHM		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK		16. SOCIAL SECURITY NO. ?		17. INFORMANT HOSP. RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Esophagus with Metastasis		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last. X					
(b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Cardiovascular disease in Failure.					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from April 10, 1967, to May 3, 1967, that (I) (we) last saw the deceased alive on May 3, 1967, and that death occurred at 2:10AM, from causes and on the date stated above.					
22a. SIGNATURE <i>Ramon P. Lopez</i>					
22b. DATE SIGNED May 3, 1967					
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez		22d. ADDRESS M.D. 7620 York Road- Towson 21204, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremated		23b. DATE THEREOF 5/6/67		23c. NAME OF CEMETERY OR CREMATORIAL Oaklawn	
24. FUNERAL DIRECTOR Connally Sons		ADDRESS 300 Avenue		23d. LOCATION (City or Town) Baltimore (County) (State)	
25a. REC'D BY REGISTRAR DATE MAY 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06465

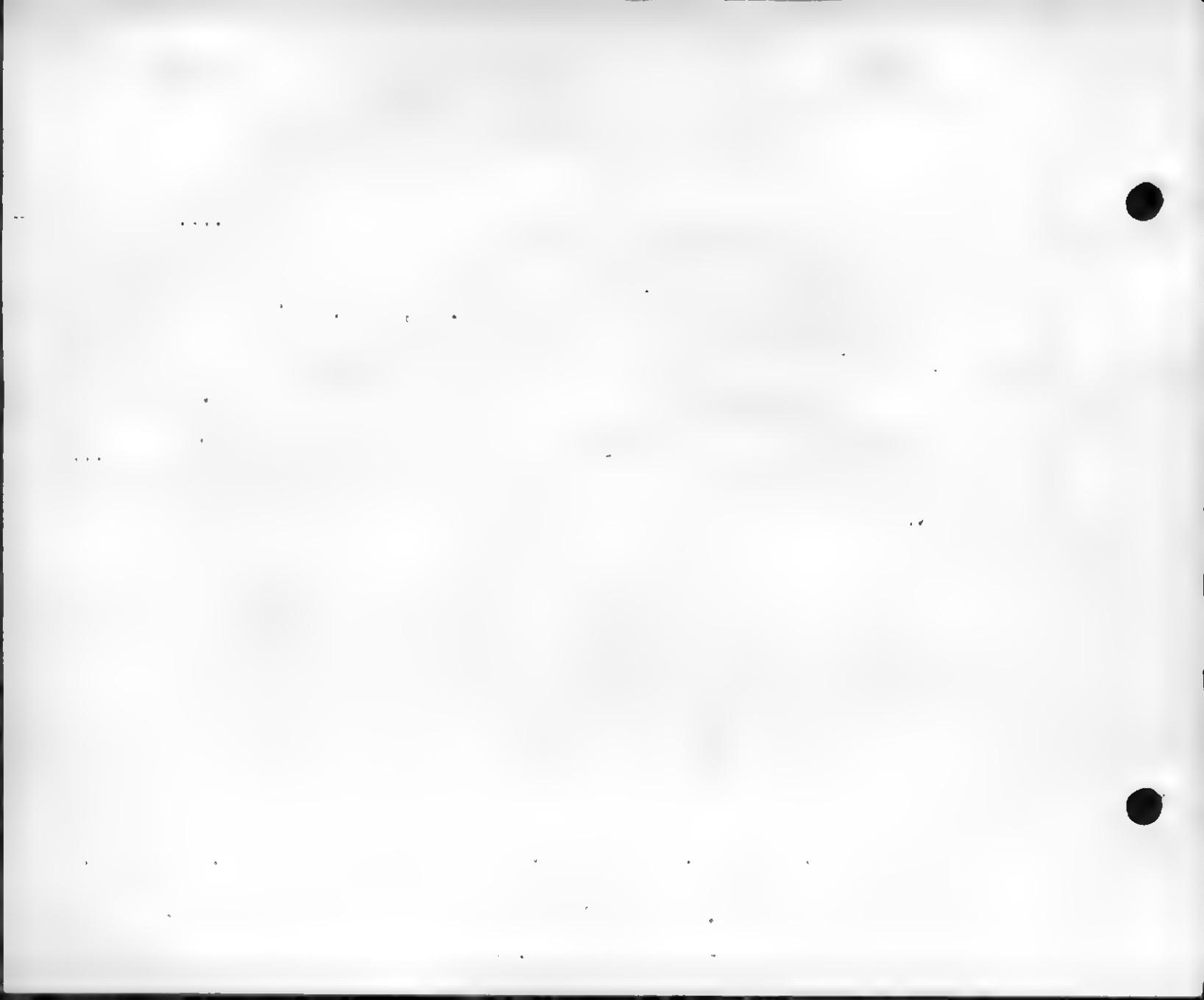
CERTIFICATE OF DEATH

06451

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney-Towson Nursing & Convalescent Home			d. STREET ADDRESS 5815 Willowton Ave....14		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)	First EDNA	Middle P.	4 DATE OF DEATH Lost YOUNG May 7 1967	Month	Day Year
5 SEX female	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1890.	9 AGE (In years last birthday) yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Maryland	
13 FATHER'S NAME Clarence Pentz			14. MOTHER'S MAIDEN NAME Laura C. Parsons		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16 SOCIAL SECURITY NO 214-01-4369B		17 INFORMANT Address Harry A. Young--5815 Willowton Ave....14	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerosis of heart & arteries</i> INTERVAL BETWEEN ONSET AND DEATH 3 yrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis, Cerebrovascular disease & Arched facies</i>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <i>to Ray 7, 1967, from causes and on the date stated above.</i>			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from <u>May 3, 1967</u> to <u>Ray 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 3, 1967</u> , and that death occurred at <u>1:45 AM</u> , from causes and on the date stated above.					
22a SIGNATURE <i>Dr. Thomas J. Horsley</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>5/8/67</u>	
22c PHYSICIAN'S NAME (Type) Dr. Thomas J. Horsley, Jr.		22d. ADDRESS 2900 Alameda...Balto... Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) burial		23b DATE THEREOF 5/9/67.		23c NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery	
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Baltimore, Md....14		ADDRESS		25a REC'D BY REGISTRAR DATE MAY 8, 1967	
				25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE
HEALTH DEPT.

TO DEPUTY
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMQ. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06463 **06452**

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE	
Baltimore		Md.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN MD Dundalk	
Dundalk		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS 7464 Berkshire Rd. # 21224 .	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
JOSEPH		ZAMENSKI	
4. DATE OF DEATH Year		Month	Day
May 14 , 1967.			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR 74 yrs. IF UNDER 24 HRS. Months Days Hours Min.	
January 16, 1893			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired		Electrician	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Pittsburgh , Pa.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Frank ZamenSKI		Stanislawa Jaworowicz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		705-03-5072 Mrs. Gertrude F. Smiley Same.	
Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which give rise to immediate cause (b), stating the underlying (c), stating the underlying cause last.		Acute Coronary occlusion arterosclerotic Heart Disease	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic asthmatic bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month Day Year Hour e.m. p.m.		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Theodore C. Patterson</i>		DATE SIGNED 105 MainSt.	
EXAMINER'S NAME (Type) Theodore C. Patterson		Address (Street, city, town, or county) Dundalk , Md. # 21222. (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-67.	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or country) 5829 Ritchie Highway, A.A.C.O., Md. (State)	
23. FUNERAL DIRECTOR Charles L. Geiler,		24a. REC'D BY REGISTRAR J. 24b. REGISTRAR'S SIGNATURE MAY 17 1967 <i>Charles Geiler</i>	
ADDRESS 901 S. Conkling St. Baltimore , 21224, Md.			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06464

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06453

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 8 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Robert	Middle H. Zittinger	Last Month May Year 2 1967
4. DATE OF DEATH	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 30, 1890	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Collector	10b. KIND OF BUSINESS OR INDUSTRY Gunther Brewery Co.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George H. Zittinger	14. MOTHER'S MAIDEN NAME Caroline Hauser	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 216-05-4032		17. INFORMANT Mrs. Marie S. Zittinger, 1517 Clearwood Rd., Balto. 34	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensated Arteriosclerotic C-V Disease		INTERVAL BETWEEN ONSET AND DEATH 1/2 yrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emetria		2 yrs	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema- Mild Diabetes			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6 Hanover Rd., Randallstown, Md.
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 5-3-67
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23b. DATE THEREOF 5/5/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd., Balto. 14		25a. REC'D BY REGISTRAR DATE MAY 5 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

